~ Oklahoma ~

Advance Directive For Health Care Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care proxy. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care proxy. If your health care proxy is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your health care proxy broad powers to make health care decisions for you. It revokes any prior advance directive for health care that you may have made. If you wish to change your Advance Directive for Health Care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your proxy, your health care provider(s), and any other person(s) to whom you have given a copy. If your proxy is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it.

It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care proxy, close family, or friends, if needed.

STATE OF OKLAHOMA
ADVANCE DIRECTIVE FOR HEALTH CARE

Written in accordance with Oklahoma Statutes Title 63 §3101.1 to §3101.16

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

1. LIVING WILL

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 Advance Directive Act, to follow my instructions as set forth below.

1. If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

2. If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent.

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

3. If I have an end-state condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicate by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective.

(Initial one option only)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

(Initial if applicable)

_____ See my more specific instructions in paragraph four (4).

4. Here you may: (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn; (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition; or, (c) do both of these.

_____

_____

_____

_____

[Attach Additional Pages, If Needed]

2. MY APPOINTMENT OF MY HEALTH CARE PROXY

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 Advance Directive Act to follow the instructions of:

_____, whom I appoint as my health care proxy.
Name of health care proxy

_____
Health Care Proxy's Address

(_____) _____
Phone

If my health care proxy is unable or unwilling to serve, I appoint:

_____, as my alternate health care proxy with the same authority.
Name of alternate health care proxy

_____
Alternate Health Care Proxy's Address

(_____) _____
Phone

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 indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

3. ANATOMICAL GIFTS

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for the purposes of:

(Initial all that apply)

_____ transplantation therapy

_____ advancement of medical science, research, or education

_____ advancement of dental science, research, or education

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:

(Initial all that apply)

_____ My entire body; or

The following body organs or parts:

( ) lungs	( ) liver	( ) pancreas	( ) heart	( ) kidneys
( ) brain	( ) skin	( ) bones/marrow	( ) tissue	( ) bloods/fluids
( ) arteries	( ) glands	( ) eyes/cornea/lens	( ) other _____	

4. GENERAL PROVISIONS

a. I understand that I must be eighteen (18) years of age or older to execute this form.
b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment, and/or artificially administered hydration, and/or nutrition shall be withheld or withdrawn.
d. 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 choice or refusal.
e. This advance directive shall be in effect until it is revoked.
f. I understand that I may revoke this advance directive at any time.
g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

SIGNATURE OF PRINCIPAL

Signed this _____ day of _____, _____
Month Year

_____, _____, _____
City County State

_____
Date of Birth (Optional)

Signature: _____

SIGNATURE OF WITNESSES

This advance directive was signed in my presence.

Witness #1

Signature: _____

_____
Address

_____, _____
City State

Witness #2

Signature: _____

_____
Address

_____, _____
City State

ADDENDUM TO THE STATE OF OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

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 that life is a gift from God and in the inherent value of human life. 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 proxy 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 proxy has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care proxy 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.

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 proxy 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 proxy 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 proxy 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 proxy 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.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care proxy 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 proxy may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

My health care proxy 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 proxy 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 proxy may not so admit me:

A nursing home **Yes** ❑ **No** ❑

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

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 checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF A FEEDING TUBE" section of the Advance Directive for Health Care document, 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.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care proxy may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care proxy may not have a feeding tube withheld or withdrawn from me.

My health care proxy may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care proxy may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care proxy 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 proxy may make health care decisions for me even if my proxy knows I am pregnant. If I have checked "No" to the following, my health care proxy may not make health care decisions for me if my proxy 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 proxy may not make health care decisions for me if he or she knows I am pregnant.

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

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my health care proxy 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 attached Addendum (pages 6-11) 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 proxy consult my clergy regarding health care decisions.

3. _____

_____

_____

[Attach Additional Pages, If Needed]

HIPAA RELEASE STATEMENT

I intend for my health care proxy 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 proxy 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.

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

Subject to any limitations in this document, my health care proxy 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.

SIGNATURES

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

Signed this _____ day of _____, _____.
Month Year

_____, _____, _____
City County State

_____
Date of Birth (Optional)

Signature: _____

This Addendum was signed in my presence.

Witness #1

Signature: _____

_____
Address

_____, _____
City State

Witness #2

Signature: _____

_____
Address

_____, _____
City State

STATEMENT OF HEALTH CARE PROXY

I understand that _____ has designated me to be his or her health care proxy
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Proxy's Signature: _____ (____) _____
Phone

Address: _____

STATEMENT OF ALTERNATE HEALTH CARE PROXY

I understand that _____ has designated me to be his or her alternate
Name of principal
health care proxy if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care proxy is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Alternate Proxy's Signature: _____ (____) _____
Phone

Address: _____

CLERGY
Optional

The principal has requested that the proxy 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 proxy to help meet the directives as described in this Advance Directive for Health Care document and attached Addendum.

Clergy's Signature: _____

Church address: _____

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

_____

_____

_____

_____

_____

_____