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 initials. 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 or am persistently unconscious:

(1) I direct that life-sustaining treatment shall be withheld or withdrawn if such treatment would only prolong my process of dying, and if my attending physician and another physician determine that I:

(a) have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

(Initial one box only) Yes ☐ No ☐

(b) am in an irreversible condition in which thought and awareness of self and environment are absent.

(Initial one box only) Yes ☐ No ☐

(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 or for individuals who have become persistently unconscious is of particular importance. I understand that if I do not initial the "yes" boxes below, artificially administered nutrition and hydration will be administered to me. I further understand that if I initial the "yes" boxes below, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water):

(a) if I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months, or

(Initial one box only) Yes ☐ No ☐

(b) if I am in an irreversible condition in which thought and awareness of self and environment are absent.

(Initial one box only) Yes ☐ No ☐

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

_____

_____

_____

(Initial one box only) Yes ☐ No ☐

II. 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 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 have indicated in the foregoing sections.

(Initial one box only) Yes ☐ No ☐

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, 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. If I **initial** the "yes" box below, I specifically donate:

Yes ☐ My entire body

or

Yes ☐ The following body organs or parts checked below:

❑ lungs	❑ liver	❑ pancreas
❑ heart	❑ kidneys	❑ brain
❑ skin	❑ bones/marrow	❑ bloods/fluids
❑ tissue	❑ arteries	❑ eyes/cornea/lens

IV. 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 of_____

_____County, Oklahoma

_____
Date of birth

_____
Optional for identification purposes

This advance directive was signed in my presence.

_____	_____
Witness (signature)	Witness (signature)
_____	_____
Residence	Residence
_____, Oklahoma	_____, Oklahoma
City	City

This form is offered as a public service by the Oklahoma Bar Association.
Permission is granted to reproduce without modification.