
INTRODUCTION TO YOUR OREGON ADVANCE DIRECTIVE

This packet contains a legal document, the **Oregon Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part A of your Oregon Advance Directive contains important information that you should read before completing your document.

Part B of your Oregon Advance Directive is the **Appointment of Health Care Representative**. This section lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Appointment of Health Care Representative is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part C of your Oregon Advance Directive is for **Health Care Instructions**. This section functions as a living will. It lets you state your wishes about medical care in the event that you are in a terminal condition, are permanently unconscious, or have an advanced progressive illness and can no longer make your own medical decisions. (One other physician must agree with your attending physician's opinion of your medical condition.)

Note: This document will be legally binding only if the person completing it is a competent adult (at least 18 years old), an emancipated minor, or is married.

How do I make my Oregon Advance Directive legal?

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses, neither of whom may be your attending physician or your health care representative or alternate. Your witnesses must also sign the document to show that they personally know you or have been provided with proof of your identity, that you signed or acknowledged your signature in their presence, that you appear to be of sound mind and free of duress, fraud or undue influence, and that they are neither your attending physician nor your health care representative or alternate.

At least one of your witnesses **cannot** be:

- related to you (by blood, marriage or adoption),
- entitled to any portion of your estate under any will or by operation of law, or
- an owner, operator or employee of your treating health care facility.

If you are a patient in a long-term care facility, one of your witnesses must be a person designated by your facility and qualified under the the rules of the Department of Human Resources.

Note: You do not need to notarize your Oregon Advance Directive.

What if I change my mind?

You can revoke your Oregon Advance Directive at any time and in any manner by which you are able to communicate your intent to revoke your document. Your revocation becomes effective once you notify your doctor or health care provider or your health care representative. If you notify your health care representative, he or she must promptly inform your doctor or health care provider of your revocation if you are unable to do so. Once your doctor or health care provider is notified of your revocation, he or she must make it part of your medical record.

Your Oregon Advance Directive will automatically be revoked if you execute a new Oregon Advance Directive, unless you have specified otherwise in your document.

COMPLETING PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

Whom should I appoint as my health care representative?

Your health care representative is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your representative can be a family member or a close friend whom you trust to make serious decisions. The person you name as your representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A health care representative may also be called an “agent,” “proxy” or “attorney-in-fact.”)

Unless he or she is related to you by blood, marriage or adoption, the person you appoint as your health care representative **cannot** be:

- your attending physician or an employee of your attending physician, or
- an owner, operator or employee of a health care facility in which you are a patient or resident, unless you appointed him or her as your representative before your admission to the facility.

You can appoint a second person as your alternate health care representative. The alternate will step in if the first person you name as representative is unable, unwilling or unavailable to act for you.

Should I add personal instructions to Part B of my Oregon Advance Directive?

If you want your health care representative to have the power to make decisions about life-sustaining treatment and artificial nutrition and hydration on your behalf, you must initial the statements under numbers 2 and 3 in Part B of your Oregon Advance Directive. If you do not initial these statements, your representative will be unable to make decisions on your behalf concerning life-sustaining treatment and artificial nutrition and hydration.

Partnership for Caring advises you not to add any further instructions to this part of the document. One of the strongest reasons for naming a health care representative is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If

COMPLETING PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE (CONTINUED)

you add instructions here, you might unintentionally restrict your representative's power to act in your best interest.

Instead, we urge you to talk with your representative about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use part C of your Oregon Advance Directive (the living will section).

What other important facts should I know?

- Part B of your Advance Directive (Appointment of Health Care Representative) will not be valid unless your health care representative and alternate sign and date the acceptance statement on page 7 of your document.
- If you appoint your spouse as your health care representative, the appointment is automatically revoked if you petition for divorce or annulment, unless you reaffirm your representative's appointment at that time.

COMPLETING PART C : HEALTH CARE INSTRUCTIONS

Can I add personal instructions to Part C of my Oregon Advance Directive?

Yes. Part C has been designed to allow you to personalize your Oregon Advance Directive. Sections 1 to 5 present specific situations in which decisions about life-sustaining treatment and artificial nutrition and hydration may need to be made. You should initial the statements that reflect your wishes. Unless you clearly outline the situations in which you would not want to receive artificial nutrition and hydration or life-sustaining treatment, your doctor may not be able to withhold or withdraw artificial feeding or life-sustaining treatment from you.

In addition, you can add personal instructions in section 6 of Part C, called “Additional Conditions or Instructions.” For example, you may want to refuse specific treatments by a statement such as, “I especially do not want cardiopulmonary resuscitation, a respirator or antibiotics.” You may also want to emphasize pain control by adding instructions such as, “I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death.”

If you have appointed a health care representative under Part B of your Advance Directive, it is a good idea to write a statement such as, “Any questions about how to interpret or when to apply my Advance Directive are to be decided by my agent.”

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Partnership for Caring booklet, “Advance Directives and End-of-Life Decisions.”

AFTER YOU HAVE COMPLETED YOUR DOCUMENTS

1. Your Oregon Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your health care representative and alternate, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your health care representative and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your document after it has been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your Oregon document.
6. Be aware that your Oregon document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called “nonhospital do-not-resuscitate orders,” are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing nonhospital do-not-resuscitate orders. Partnership for Caring does not distribute these forms. We suggest you speak to your physician.

If you would like more information about this topic contact Partnership for Caring or consult the booklet “Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions.”

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OREGON ADVANCE DIRECTIVE

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your 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.

Print your NAME, BIRTHDATE AND ADDRESS here:

Name _____ Birthdate _____

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 _____
(name of health care representative)

as my 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 _____

and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't 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.

1. LIMITS.

Special Conditions or Instructions:

INITIAL IF THIS APPLIES:

_____ I have executed a Health Care Instruction 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)

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.

- 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 INSTRUCTIONS.

(Insert description of what you want done.)

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.

___ 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)

PART D: DECLARATION OF WITNESSES

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)

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 a health care facility where the person is a patient or resident.

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)