Advance Directive - OREGON

Providence St. Joseph Health

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative.

If you do not have an effective health care representative appointment and become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

- If you have completed an advance directive in the past, this new advance directive will replace any older directive.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
- If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.
- In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

This advance directive belongs to: (please print your name on this line) **Date of Birth**

1. ABOUT ME

Name: _____ Date of Birth: _____

Telephone numbers: (Home) _____ (Work) _____

(Cell) _____ E-mail: _____

Address: _____

2. MY HEALTH CARE REPRESENTATIVE

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

Name: _____ Relationship: _____

Telephone numbers: (Home) _____ (Work) _____

(Cell) _____ E-mail: _____

Address: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

First alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home) _____ (Work) _____

(Cell) _____ E-mail: _____

Address: _____

2. MY HEALTH CARE REPRESENTATIVE (continued)

Second alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home)_____ (Work) _____

(Cell) _____ E-mail: _____

Address: _____

3. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE

If you wish to give instructions to your health care representative about your health care decisions, initial one of the following three statements:

_____ To the extent appropriate, my health care representative must follow my instructions.

_____ My instructions are guidelines for my health care representative to consider when making decisions about my care.

_____ Other instructions:

_____

_____

_____

_____

_____

4. DIRECTIONS REGARDING MY END OF LIFE CARE

In filling out these directions, keep the following in mind:

- The term "as my health care provider recommends" means that you want your health care provider to use life support if your health care provider believes it could be helpful, and that you want your health care provider to discontinue life support if your health care provider believes it is not helping your health condition or symptoms.
- The term "life support" means any medical treatment that maintains life by sustaining, restoring or replacing a vital function.
- The term "tube feeding" means artificially administered food and water.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will receive care for your comfort and cleanliness no matter what choices you make.

A. Statement Regarding End of Life Care.

You may initial the statement below if you agree with it. If you initial the statement you may, but you do not have to, list one or more conditions for which you do not want to receive life support.

_____ 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 health care provider to allow me to die naturally if my health care provider and another knowledgeable health care provider confirm that I am in any of the medical conditions listed below.

_____

_____

_____

_____

_____

_____

4. DIRECTIONS REGARDING MY END OF LIFE CARE (continued)

B. Additional Directions Regarding End of Life Care.

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

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

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

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

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

c. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, 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:

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

This advance directive belongs to: (please print your name on this line) **Date of Birth**

4. DIRECTIONS REGARDING MY END OF LIFE CARE (continued)

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

INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my health care provider recommends.

_____ I DO NOT WANT tube feeding.

INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my health care provider recommends.

_____ I DO NOT WANT life support.

C. Additional Instruction. You may attach to this document any writing or recording of your values and beliefs related to health care decisions. These attachments will serve as guidelines for health care providers. Attachments may include a description of what you would like to happen if you are close to death, if you are permanently unconscious, if you have an advanced progressive illness or if you are suffering permanent and severe pain.

_____

_____

_____

_____

_____

_____

_____

This advance directive belongs to: (please print your name on this line) **Date of Birth**

5. MY SIGNATURE

My Signature: _____ Date:_____

6. WITNESS

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of OREGON

County of _____

Signed (or attested) before me on (date) _____ , 2_____ ,

by (name(s) of individual(s))_____ .

_____

Notary Public - State of Oregon

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form.

In addition, I am not the person's health care representative or alternate health care representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____ Date: _____

Witness Name (print): _____

Signature: _____ Date: _____

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed Name: _____

Signature or other verification of acceptance: _____ Date: _____

First alternate health care representative:

Printed Name: _____

Signature or other verification of acceptance: _____ Date: _____

Second alternate health care representative:

Printed Name: _____

Signature or other verification of acceptance: _____ Date: _____

Providence St. Joseph Health

Submit a copy of your completed advance directive.

Once you have signed your advance directive and it has been witnessed, keep the original and make copies of pages 1-8 to send to your:

- Health care representative
- Family
- Friends
- Medical providers
- Hospital

Options for returning your completed advance directive:

1. Return a **COPY** to your preferred Providence St. Joseph Health doctor or hospital at your next visit.
2. Return a **COPY** by using the self-addressed stamped envelope (if available).
3. Return by fax to your Providence St. Joseph Health hospital:

Providence Hood River Memorial Hospital
Providence Medford Medical Center
Providence Milwaukie Hospital
Providence Newberg Medical Center
Providence Portland Medical Center
Providence Seaside Hospital
Providence St. Vincent Medical Center
Providence Willamette Falls Medical Center
Fax to 503-215-7494

For hospitals not listed, please contact your hospital for the correct fax number.

If you have any questions related to completing or returning your advance directive, please contact us at:

Providence.org/InstituteForHumanCaring
424-212-5444