Advance Directive – OREGON

Name: _____Date of Birth: ____/____/____

Telephone numbers: (home) _____; (cell) _____

Address:_____

Email: _____

Complete at least **ONE** option from **Step 1** and **Step 2** and complete **Step 3** and **Step 4**

Step 1: Choose a health care agent.

CHOOSE **ONE** OR **TWO** BOXES

☐ I choose _____ Relationship _____
(phone number - - and/or email_____) as my primary health care agent to speak for me in making health care decisions if I become unable to speak for myself.

☐ I choose _____; Relationship _____
Phone number - - and/or email_____) as my secondary health care agent who can speak for me in making health care decisions if I become unable to speak for myself and my primary health care agent is unable to serve.

Step 2: Provide guidance to my health care agent & doctors.

In working together to make treatment decisions and plans for my care, please consider my general preferences described below:

CHOOSE **ONE** BOX ONLY

☐ I am not sure at this time which statements below I most agree with. I trust my health care agent to do what is best for me.

☐ I want to continue living even if my quality of life seems low to others and I am unable to communicate with people. In general, I would accept support of my breathing, heart, and kidney function by machines that require me to be in a hospital or special care unit.

☐ Life is precious, but I understand that we all die sometime. I want to live as long as I can interact with others and can enjoy some quality of life. I would accept intensive treatments only if I had a reasonable chance of getting better. I would refuse long-term support by intensive medications or machines if my quality of life was poor and I was not able to communicate with people.

☐ It is most important to me to avoid suffering. I do not want extraordinary medical treatments, such as breathing machines or cardiopulmonary resuscitation (CPR). If my natural body functions fail, I would refuse treatments and choose to die naturally.

Is there anything your doctors should know about you to provide you with the best care possible?

_____

_____

Step 3: Complete and sign the form in front of EITHER 1) two witnesses OR 2) notary public and have Agent accept

Signature _____ Date:_____

Address: _____

SIGNATURE OF FIRST WITNESS
I declare under penalty of perjury under the laws of Oregon that:

- The individual completing this form is personally known to me or has provided proof of identity;
- The individual completing this form 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.
- I am not the individual's health care provider
- I am not the individual's health care representative or alternative health care representative.

Signature:_____

Print Name:_____

Address:_____

SIGNATURE OF SECOND WITNESS
I declare under penalty of perjury under the laws of Oregon that:

- The individual completing this form is personally known to me or has provided proof of identity;
- The individual completing this form 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.
- I am not the individual's health care provider
- I am not the individual's health care representative or alternative health care representative.
- I am not a relative/spouse/adoptee, heir/beneficiary of the individual

Signature:_____

Print Name:_____

Address:_____

2. Option 2 – Notary
State of Oregon
County of _____

I certify that I know or have satisfactory evidence that _____ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.
(Notary Seal)

Date: _____
Signature of Notary Public: _____
Title: _____
My appointment expires: _____

Step 4: Health Care Representative's(s') acceptance of the appointment.
I hereby accept the appointment to be the health care agent for _____

Name: _____

I hereby accept the appointment to be the secondary health care agent for _____

Name: _____

Name: _____ Date of Birth: _____

Advance Directive – OREGON

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 healthcare representative. If you have completed a form appointing a health are representative in the past, this new form will replace any older form. 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 you become too sick to speak for yourself and do not have an effective health care representative appointment, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635(2).

Instructions for Step 1: Appointing a health care agent.

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Provide name and contact information for this person, along with one additional individual

Choose a family member or friend who:

- Is 18 or older and knows you well
- Is willing to do this for you
- Is able to make difficult decisions based on your wishes
- Will effectively communicate the information you provide in this packet to health
- Agrees to accept the appointment

Your representative cannot be your doctor or someone who works at the hospital or clinic where you are receiving care unless he or she is a member of your family.

Your health care representative can:

- Decide where you will receive care
- Select or dismiss health care providers
- Say yes/no to medications, tests, treatments
- Take legal action to carry out your wishes

Your health care representative CANNOT authorize:

- Electro-convulsive therapy
- Psycho-surgery
- Sterilization
- Abortion
- Life-sustaining procedures*
- Nutrition & Hydration*

*Refusal permissible if expressly authorized or if specific conditions are met (ex: individual has been medical confirmed to be in a terminal condition or permanently unconscious)

Instructions for Step 2: Information for my health care agent & doctors in making decisions for my care.

Indicate your health care wishes

1. Select one of the choices to provide guidance concerning life support treatments. Below is some information about some life support treatments that may or may not be successful in helping you live longer.

   CPR or cardiopulmonary resuscitation: This may involve (1) Pressing hard on your chest to keep your blood pumping, (2) Electrical shocks to jump-start your heart, (3) Medicines in your veins.

   Ask your health care providers for more information as needed.

