OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE PLANNING

If I, _____, become incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below:

I. Health Care Directives

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:

Terminal Condition

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 **ONLY ONE** option in this Section)

Summary of Options		
ALL – ***Yes to life-support, CPR, tube feedings and hydration***	***SOME -*** ***No to CPR and life support but Yes to tube feedings and hydration***	***NONE -*** ***No to CPR, life-support, tube feedings and hydration***
I direct that I be given life-sustaining treatment, including cardiopulmonary resuscitation (CPR); and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.	I direct that I not be given life-sustaining treatment, including CPR; except 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 CPR and artificially administered nutrition and hydration.
_____ INITIAL ABOVE	_____ INITIAL ABOVE	_____ INITIAL ABOVE

Additional instructions or comments (optional): _____

_____

_____

(Initial below if you've written additional instructions/comments above)

_____

Persistently Unconscious

If I become persistently unconscious, that is, I have a permanent or irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial **ONLY ONE** option in this Section)

Summary of Options		
ALL – ***Yes to life-support, CPR, tube feedings and hydration***	***SOME -*** ***No to CPR and life support but Yes to tube feedings and hydration***	***NONE -*** ***No to CPR, life-support, tube feedings and hydration***
I direct that I be given life-sustaining treatment, including cardiopulmonary resuscitation (CPR); and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.	I direct that I not be given life-sustaining treatment, including CPR; except, 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 CPR and artificially administered nutrition and hydration.
_____ INITIAL ABOVE	_____ INITIAL ABOVE	_____ INITIAL ABOVE

Additional instructions or comments (optional): _____

_____

_____

_____

_____

(Initial below if you've written additional instructions or comments immediately above)

_____

End-Stage Condition

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

(Initial **ONLY ONE** option in this Section)

Summary of Options		
ALL – ***Yes to life-support, CPR, tube feedings and hydration***	***SOME -*** ***No to CPR and life support but Yes to tube feedings and hydration***	***NONE -*** ***No to CPR, life-support, tube feedings and hydration***
I direct that I be given life-sustaining treatment, including cardiopulmonary resuscitation (CPR); and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.	I direct that I not be given life-sustaining treatment, including CPR; except, 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 CPR, and artificially administered nutrition and hydration.
_____ INITIAL ABOVE	_____ INITIAL ABOVE	_____ INITIAL ABOVE

Additional instructions or comments (optional): _____

_____

_____

_____

_____

(Initial below if you've written additional instructions or comments immediately above)

_____

OPTIONAL SECTION: Add Other Conditions or Additional Instructions or Comments

OTHER. Here you may:

a) describe **other conditions** in which you would want life-sustaining treatment, including CPR and/or artificially administered nutrition and hydration provided, withheld, or withdrawn;

b) give **more specific instructions** about your wishes concerning life-sustaining treatment, including CPR and/or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition;

c) do **both** of the above;

d) state, in your own words, that during a course of pregnancy, if applicable, you specifically authorize that life-sustaining treatment, including CPR, artificially administered hydration and/or nutrition be withheld or withdrawn; or

e) add any other additional instructions or comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Initial below if you've written additional instructions or comments immediately above)

_____

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 under the Oklahoma Advance Directive Act to follow the instructions of the following named individual, whom I appoint as my health care proxy:

Name:_____

If my health care proxy is unable or unwilling to serve, I appoint the following named individual as my alternate health care proxy with the same authority:

Name:_____

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 and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy **ONLY** as I have 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.

III. Organ and Tissue Donation (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 or tissue be donated as follows:

If I initial in one or more of the "YES" columns below, I specifically donate:

	Initial for "YES"
My entire body	
OR ONLY THE FOLLOWING BODY ORGANS/PARTS	**Initial One or More Below to Indicate "YES"**
Lungs	
Liver	
Arteries	
Pancreas	
Heart	
Glands	
Kidneys	
Brain	
Tissue	
Skin	
Bones/Marrow	
Eyes/Cornea/Lens	
Bloods/Fluids	
Other	

DONATION IS FOR PURPOSES OF:	**Initial Below**
Transplantation Therapy	
OR	**Initial One or Both Below**
Advancement of medical science research, or education	
Advancement of dental science, research, or education	

Note: Death means either the irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to sign this form.

b. I understand that my witnesses are eighteen (18) years of age or older and are not related to me and will 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, including CPR, artificially administered hydration and/or artificially administered nutrition UNLESS I have, in my own words, specifically authorized [see Section I.4(d) above] that, during a course of pregnancy, life-sustaining treatment, including CPR, 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 for Health Care Planning shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.

e. This Advance Directive for Health Care Planning shall be in effect until my death or until it is revoked by me.

f. I understand that I may revoke this Advance Directive for Health Care Planning at any time.

g. I understand that if I have executed a prior advance directive for health care planning, my prior advance directive(s) for health care planning will be revoked by signing this document.

h. I understand the full importance of this Advance Directive for Health Care Planning, and I am emotionally and mentally competent to make this Advance Directive for Health Care Planning.

i. I understand that my physician(s) will 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.

Signed this _____ day of _____, 20___.

_____
(Signature)

City: _____

County and State: _____

Date of Birth: _____
(**Optional for identification purposes**)

This Oklahoma Advance Directive for Health Care was signed in my presence:

_____	_____
Date	Witness
	_____, Oklahoma
	Residence
_____	_____
Date	Witness
	_____, Oklahoma
	Residence