ADVANCE DIRECTIVES TO PHYSICIANS FOR HEALTH CARE
OF
JOHN DOE

Directive made this th day of , 20__

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, and do hereby declare:

IF MY DEATH SHOULD APPEAR IMMINENT, I MOST URGENTLY REQUEST THAT A CATHOLIC PRIEST SHOULD BE CALLED IMMEDIATELY TO ADMINISTER TO ME THE LAST RITES OF THE CATHOLIC CHURCH, WHETHER I AM CONSCIOUS OR NOT, AND NO MATTER HOW MANY TIMES SUCH AN EMERGENCY MAY OCCUR.

LIVING WILL

If my attending physician and another physician, preferably Dr. , and if he is unable or unwilling, another physician selected by my husband to determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other healthcare providers, pursuant to the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, to withhold or withdraw treatment from me under the circumstances as I have indicated below by my signature. **However, I direct that I will be given treatment that is necessary for my comfort and to alleviate my pain**.

If I have a terminal condition:

I direct that life-sustaining treatment, **except for pain medication,** shall be withheld or withdrawn if such treatment would only prolong my process of dying, and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

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 is of particular importance. I further understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition and hydration (food and water).

NO SIGNATURE

If I am persistently unconscious:

I direct that life sustaining treatment, **except for pain medication**, be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

_____ I understand that the subject of the artificial administration of nutrition and hydration (food and water) for individuals who have become persistently unconscious is of particular importance. I further understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition and hydration (food and water).

NO SIGNATURE

APPOINTMENT OF HEALTH CARE PROXY

If Dr. , is available, he, 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 my husband/wife , whom I appoint as my Health Care Proxy. If my husband/wife 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 alternative health care proxy only as I indicate in the following sections.

If I have a terminal condition:

> I authorize my health care proxy to direct that life-sustaining treatment, except **for pain medication**, 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 have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.
>
> _____ 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 is of particular importance. I further understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition and hydration (food and water).

If I am persistently unconscious:

> I authorize my health care proxy to direct that life sustaining treatment, **except for pain medication**, be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

NO SIGNATURE

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 or 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 body, including the brain stem. I specifically donate:

☐ My entire body; or

☐ The following body organs or parts: ☐ eyes/cornea/lens, ☐ lungs, ☐ liver, ☐ pancreas, ☐ heart, ☐ kidneys, ☐ brain, ☐ bloods/fluids, ☐ tissue, ☐ arteries, ☐ skin, ☐ glands, ☐ bones/marrow, ☐ other

CONFLICTING PROVISION

I understand that if I have completed both a Living Will and have appointed a Health Care Proxy, and if there is a conflict between my Health Care Proxy's decision and my Living Will, my Living Will shall take precedence unless I indicate otherwise.

GENERAL PROVISIONS

In the absence of my ability to give directions regarding my 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, **except for pain medication, nutrition and hydration,** and I accept the consequences of such refusal.

This advance directive shall be in effect until it is revoked and a photocopy may be used instead of the original.

I understand that I may revoke this advance directive at any time.

I understand and agree that if I have any prior directives and if I sign this advance directive, my prior directives are revoked.

I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

Signature: _____

Printed Name: _____

A T T E S T A T I O N

The declarant has been personally known to me and I believe said declarant to be of sound mind. I am eighteen (18) years of age or older; I am not related by blood or marriage; I am not financially responsible for the medical care of the declarant; I am not entitled to any portion of the estate of the declarant pursuant to any will of the declarant, any codicil thereto, or by operation of law; I am not the attending physician; I am not an employee of the attending physician or a health care facility in which the declarant is a patient; I am not a patient in a health care facility in which the declarant is a patient; and I do not have a claim against any portion of the estate of the declarant upon the death of the declarant.

_____

WITNESS
Oklahoma City, Oklahoma.

_____

WITNESS
Oklahoma City, Oklahoma.

STATE OF OKLAHOMA)
) ss:
COUNTY OF OKLAHOMA)

Before me, the undersigned authority in and for said county and state, on this day personally appeared , declarant, _____, and _____ witnesses, whose names are subscribed to the foregoing instrument in their respective capacities, and, all of said persons being by me duly sworn, the declarant declared to me and to the said witnesses in my presence that said instrument is his "Directive of Physicians," and that the declarant has willingly and voluntarily made and executed it as the free act and deed of the declarant for the purposes therein expresses.

The foregoing instrument was acknowledged before me this day of , 20__.

_____
NOTARY PUBLIC

My Commission expires: