RIVER ROAD SURGERY CENTER

An advanced Directive is a set of instructions that explain the specific health care measures a person wants if he or she should have a terminal illness or injury and become incapable of indicating whether to continue curative and life-sustaining treatment, or to remove life support systems. The person must develop the advance directive while he or she is able to clearly and definitively express him or herself verbally, in writing, or in sign language. It must express the person's own free will regarding their health care, not the will of anyone else. It does not affect routine care for cleanliness and comfort, which must be given whether or not there is an advance directive.

In Oregon, the Health Care Decisions Act ORS 127.505 – 127.660 and ORS 127.995 allows an individual to preauthorize health care representatives to allow the natural dying process if he or she is medically confirmed to be in one of the conditions described in his or her health care instructions. This Act does not authorize euthanasia, assisted suicide or any overt action to end the person's life.

Requirements

Witnesses: Two adults, at least one of them not related to the person by blood or marriage nor entitled to any portion of the person's estate, must witness or acknowledge the person's signing the advance directive. The person's attending physician, attorney-in-fact, and health care or residential staff may not serve as witnesses.

Health Care Instructions: These may either be general, or relate to the four specific conditions outlined below. However, general instructions, such as the person never wishes to be placed on life support, may be too vague and not provide for a situation in which an accident or emergency requires that the person be placed on life support temporarily. Specific instructions regarding the person's wishes in each of the four scenarios listed below are preferred. Some hospitals' social workers or chaplains will provide instructions and forms for advance directives. The patient's physician can determine whether any of these four conditions apply:

1. **Close to death:** Terminal illness in which death is imminent with or without treatment, and where life support will only postpone the moment of death.

2. **Permanently unconscious:** Completely lacking an awareness of self and external environment, with no reasonable possibility of a return to a conscious state.

3. **Advanced progressive illness:** A progressive illness that will be fatal and is unlikely to improve.

4. **Extraordinary suffering:** Illness or condition in which life support will not improve the person's medical condition and would cause the person permanent and severe pain.

Options

Health Care Representative: An advance directive can appoint someone who is at least 18 years of age to make medical decisions for the person when that individual is not able to do so. Among the decisions this health care representative can make is whether to withhold or remove life support, food or hydration. The health care representative and an alternate must sign the document, accepting their appointment. The patient should appoint a health care representative that he or she trusts completely. A patient can voluntarily revoke their appointment of a health care representative at any time. A general Durable Power of Attorney, which is for financial affairs, does not include authority to make health care decisions.

Special instructions and conditions: These can be inserted into the Health Care Plan or included for the health care representative as long as they don't deal with the distribution of property.

Duration and changes: The advance directive can be designated in effect for a limited period of time. If not, it is in effect until the person revokes it in writing, or dies. A person can cross out words or add words to his or her advance directive to make it better express his or her wishes.

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ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

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.

In this document, you can write 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 Instruction)

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 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 or add words that better express your wishes. Witnesses must sign PART D.
- Oregon law does not require that a practicioner comply with the wishes in your directive if they conflict with his/her moral and ethical judgment.

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ADVANCE DIRECTIVE

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 _____ as my health care representative.

My representative's address is _____

and telephone number is _____.

I appoint _____ 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.

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE (CONTINUED)

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.)

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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 if your physician believes it could be helpful 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 that 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.

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

3. 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:
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.

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6. Additional Conditions or Instructions. (Insert description of what you want done.)

_____
_____
_____
_____

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

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 unless I appointed a health care representative after signing the health care power of attorney.

_____ 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 the 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.

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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. 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. 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.

_____

(Signature of Health Care Representative/Date)

_____

(Printed Name)

_____

(Signature of Alternate Health Care Representative/Date)

_____

(Printed Name)