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ADVANCE DIRECTIVE CHECKLIST

I, _____, being of sound mind and willfully and voluntarily make this declaration to be followed if I become incapacitated. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measure to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I [ ] do [ ] not want cardiac resuscitation.

I [ ] do [ ] not want mechanical respiration.

I [ ] do [ ] not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water)

I [ ] do [ ] not want blood or blood products.

I [ ] do [ ] not want any form of surgery or invasive diagnostic tests.

I [ ] do [ ] not want kidney dialysis.

I [ ] do [ ] not want antibiotics.

I realize that if I do not specifically indicate any preference regarding any of the forms of treatment listed above, I will receive that form of treatment.

I [ ] do [ ] not designate another person as my surrogate to make medical treatment decisions for me if I should be incapacitated in a terminal condition, in a state of permanent unconsciousness, or in ay case where I cannot make these decisions myself. Name of surrogate_____

I made this declaration on the _____day of _____year.

Witness_____Patient_____

_____ _____

Signature Signature