Oregon Advance Directive for Health Care

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes. It is recommended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

- In sections 1, 2, 5, 6 and 7 you appoint a health care representative.
- In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

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 or are unable to make your own medical decisions. The person is called a health care representative. If you do not have an effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

If you have completed an advance directive in the past, this new advance directive will replace any older directive.

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 your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.

In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

Advance Directive Form

1. About me		
Name (first, middle, last):		Date of birth:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

2. My health care representative		
I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.		
Name (first, middle, last):		Relationship:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me, or if I cancel the first healthcare representative's appointment.

First alternate health care representative		
Name (first, middle, last):		Relationship:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

Second alternate health care representative		
Name (first, middle, last):		Relationship:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

3. My health care instructions

This section is the place for you to express your wishes, values and goals for care. Your instructions provide guidance for your health care representative and health care providers.

You can provide guidance on your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

A. My health care decisions

There are three situations below for you to express your wishes. They will help you think about the kinds of life support decisions your health care representative could face. For each, choose the one option that most closely fits your wishes.

a. **Terminal condition**
This is what I want if:

- I have an illness that cannot be cured or reversed

  AND

- My health care providers believe it will result in my death within six months, regardless of any treatments.

Initial one option only	
_____	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
_____	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
_____	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
_____	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

b. **Advanced progressive illness**
This is what I want if:

- I have an illness that is in an advanced stage.
  AND
- My health care providers believe it will not improve and will very likely get worse over time and result in death.
  AND
- My health care providers believe I will never be able to:
  - » Communicate
  - » Swallow food and water safely
  - » Care for myself
  - » Recognize my family and other people

Initial one option only	
_____	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
_____	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
_____	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
_____	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

c. **Permanently unconscious**
This is what I want if:

- I am not conscious.
  AND
- If my health care providers believe it is very unlikely that I will ever become conscious again.

Initial one option only	
_____	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
_____	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
_____	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

_____ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

You may write in the space below or attach pages to say more about what kind of care you want or do not want.

B. What matters most to me and for me

This section only applies when you are in a terminal condition, have an advanced progressive illness or are permanently unconscious. If you wish to use this section, you can communicate the things that are really important to you and for you. This will help your health care representative.

This is what you should know about what is important to me about my life:

This is what I value the most about my life:

This is what is important for me about my life:

I do not want life-sustaining procedures if I can not be supported and be able to engage in the following ways:

Initial all that apply

_____ Express my needs

_____ Be free from long-term severe pain and suffering

_____ Know who I am and who I am with

_____ Live without being hooked up to mechanical life support

_____ Participate in activities that have meaning to me, such as:

If you want to say more to help your health care representative understand what matters most to you, write it here. (For example: I do not want care if it will result in…)

C. My spiritual beliefs

Do you have spiritual or religious beliefs you want your health care representative and those taking care of you to know? They can be rituals, sacraments, denying blood product transfusions and more.

You may write in the space below or attach pages to say more about your spiritual or religious beliefs.

4. More information

Use this section if you want your health care representative and health care providers to have more information about you.

A. Life and values

Below you can share about your life and values. This can help your health care representative and health care providers make decisions about your health care. This might include family history, experiences with health care, cultural background, career, social support system and more.

You may write in the space below or attach pages to say more about your life, beliefs and values.

B. Place of care

If there is a choice about where you receive care, what do you prefer? Are there places you want or do not want to receive care? (For example, a hospital, a nursing home, a mental health facility, an adult foster home, assisted living, your home.)

You may write in the space below or attach pages to say more about where you prefer to receive care or not receive care.

C. Other

You may attach to this form other documents you think will be helpful to your health care representative and health care providers. What you attach will be part of your Advance Directive.

You may list documents you have attached in the space below.

D. Inform others

You can allow your health care representative to authorize your health care providers to the extent permitted by state and federal privacy laws to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name (first, middle, last):		Relationship:
Telephone numbers: Home	Work	Cell
Address:		E-mail:

5. My signature

My signature

Date

6. Witness

Complete either A or B when you sign

A. Notary

State of _____

County of _____

Signed or attested before me on _____ by _____
Date

_____

Notary Public State of Oregon

B. Witness Declaration

The person completing this form is personally known to me or has provided proof of identity, 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. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

_____
Witness name (print)

_____ _____
Signature Date

_____
Witness name (print)

_____ _____
Signature Date

7. Acceptance by my health care representative

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name

Signature or other verification of acceptance | Date

First alternate health care representative:

Printed name

Signature or other verification of acceptance | Date

Second alternate health care representative:

Printed name

Signature or other verification of acceptance | Date

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Health Information Center at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us.