Advance Health Care Directive

OREGON

LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

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LIFE CARE **planning**

my values, my choices, my care

Full name:
Medical record number:

Introduction

This advance health care directive allows you to share your values, your choices, and your instructions about your future health care. This form may be used to:

- Name someone you trust to make health care decisions for you (your health care representative/agent), OR
- Provide written instructions about your future health care, OR
- Both name a health care representative/agent AND provide written instructions for future health care

Part 1 gives you an opportunity to share your values and what is important to you.

Part 2 allows you think about your future health care wishes.

Part 3 allows you to guide your agent's decision-making by stating your hopes and wishes.

Part 4 allows you to make your advance health care directive legally valid in the state of Oregon.

Part A provides important information about the advance directive.

Part B appoints a health care representative/agent.

Part C allows you to give written instructions about your future health care.

Part D is a declaration of witnesses.

Part E is acceptance by your health care representative/agent.

Part 5 prepares you to share your wishes and this document with others.

You are free to modify this form.

This advance health care directive will replace any advance health care directive you have completed in the past. In the future, if you want to cancel or change your named agent, you must do so in writing and sign that document, or you can inform your health care provider in person.

Full name:

Medical record number: Date of birth:

Mailing address:

Home phone: Cell phone:

Work phone: Email:

Document type: Advance Directive

Full name: _____
Medical record number: _____

Part 1. My Values

I want my agent and loved ones to know what matters most to me, so that they can make decisions about my health care that match who I am and what is important to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, whom I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

1. If I were having a really good day, I would be doing the following:

2. What matters most to me is:

3. Life would no longer be worth living if I were not able to:

Full name: _____
Medical record number: _____

Part 2. My Health Care Instructions: My Choices, My Care

My choices and preferences for my health care are as follows:

If I become unable to communicate or make my own choices, I ask that my health care agent represent my choices as detailed below and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are unable to make decisions on my behalf, this document represents my wishes.

Note: If you choose not to provide written instructions, your health care agent will make decisions based on your spoken directions. If your directions are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.

1. Treatments to prolong life

Consider the following situation:

You have a sudden accident or stroke.

Doctors have determined you have a brain injury, leaving you unable to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine) or a feeding tube, are required to keep you alive. In this situation, what would you want?

I would want to be kept comfortable and:

choose one

- ☐ I would want to STOP life-sustaining treatment. I realize this would probably lead me to die sooner than if I were to continue treatment.
- ☐ I would want life-sustaining treatments to continue as long as possible.

Please provide any additional instructions about life-sustaining treatments. For example, you may want to state a specific time period that you would want to be kept alive if there were no improvement to your health.

Full name: _____
Medical record number: _____

2. CPR (Cardiopulmonary resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* If you would like additional information about CPR, please request the brochure called **CPR: My Choice.**

In the event that your heart and breathing stop, what would you want?

choose one

- ☐ I always want CPR attempted.
- ☐ I never want CPR attempted but, rather, want to permit a natural death.†
- ☐ I want CPR attempted unless the doctor treating me determines any of the following:
  - I have an incurable illness or injury and am dying, OR
  - I have no reasonable chance of survival if my heart or breathing stops, OR
  - I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause significant suffering.

* Research shows that if you are in a hospital and get CPR, you have a 17% chance of it working and you leaving the hospital alive. Peberdy MA, Kaye W, Ornato JP, et al. Cardiopulmonary resuscitation in adults in the hospital: A report of 14,720 cardiac arrests from the National Registry of Cardiopulmonary Resuscitation. Resuscitation - 2003; 58 297-308.

† If you are certain you do not want CPR, please discuss other documents you may want to complete with your physician.

Full name: _____
Medical record number: _____

Part 3. My Hopes and Wishes (Optional)

1. My thoughts and feelings about where I would prefer to die:

2. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, rituals, music, etc.):

3. Religious or spiritual affiliation:

I am of the _____ faith, and am a member of (faith/spiritual community) _____ in (city) _____, (phone #) _____. I would like my agent to notify them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

Full name:
Medical record number:

4. Other wishes/instructions:

Organ donation

If you are interested in donating organs when you die, you can declare your donor status when getting or renewing a driver's license or by registering through the donor registry found at donatelifenw.org/register-now.

Full name: _____
Medical record number: _____

Part 4. Making This Document Legally Valid

To make your advance health care directive legally valid in Oregon, you must complete the following document. It must be signed by 2 witnesses.

Oregon 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 instructions)

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 advance 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 Advance Directive

Name: _____

Birth date: _____

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.

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.)

3. Tube feeding

One sort of life support is food and water supplied artificially by a 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.

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.

6. Additional conditions or instructions

(Insert a description of what you want done.)

_____

_____

_____

_____

7. Other documents

A "health care power of attorney" is a 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 this 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.

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)

When you have completed your form, please keep your original and mail a copy to:
Kaiser Permanente Process Center
Medical Records Department, Advance Directive
10220 SE Sunnyside Road, Clackamas, OR 97015-9734

Full name: _____
Medical record number: _____

Part 5. Next Steps

Now that you have completed your advance health care directive, you should also take the following steps.

Discuss:

- Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to perform this important job for you in the future.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care representative/agent is and what your wishes are.

Give copies:

- Give your health care agent a copy of your advance health care directive.
- Give a copy of your advance health care directive to your doctor or your local Kaiser Permanente Member Services Department.
- Make a copy for yourself and keep it where it can be easily found.

Take with you:

- If you go to a hospital or nursing home, take a copy of your advance health care directive and ask that it be placed in your medical record.
- Take a copy with you any time you will be away from home for an extended period of time.

Review regularly:

- Review your health care wishes whenever any of the "Five D's" occur:

  Decade — when you start each new decade of your life

  Death — whenever you experience the death of a loved one

  Divorce — when you experience a divorce or other major family change

  Diagnosis — when you are diagnosed with a serious health condition

  Decline — when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own

Changing your advance health care directive:

If your wishes change, fill out a new advance health care directive, tell your agent and your family, and provide a copy to Kaiser Permanente.

Full name: _____
Medical record number: _____

Copies of this document have been given to:

- Primary (main) health care agent

  Full name: _____

  Telephone: _____

- Alternate health care agent #1

  Full name: _____

  Telephone: _____

- Alternate health care agent #2

  Full name: _____

  Telephone: _____

- Health care provider/clinic

  Name: _____

  Telephone: _____

- Others

  Name: _____

  Telephone: _____

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Need additional assistance?
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