DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For Oklahoma Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Oklahoma Residents

Statutory Compliant
Advance Directive for
Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Oklahoma Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Oklahoma state legislature has provided statutes guiding the construction of an Advance Directive for Health Care for use by the public (containing both a 'Living Will' and a 'Health Care Proxy Appointment'). As the content of this documents was designed by your state government it should be in compliance with all applicable statutes and laws.

There is an introduction to summarizes the scope and purpose of the document, as well as providing further directions for completion. Read it carefully to ensure that your advance directive is fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:
ADVANCE DIRECTIVE FOR HEALTH CARE
and Personal Instructions

(Okla. Stat. Title:63, Ch.60: §3101.1 to §3101.16)

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1. INTRODUCTION: *The Oklahoma Advance Directive for Health Care is designed to assist those wishing to refuse life-sustaining treatment in terminal or persistently unconscious conditions, or in an 'end-stage' condition (§3101.3). A **terminal** condition is defined as: "an incurable and irreversible condition that, even with the administration of life-sustaining treatment, will...result in death within six (6) months"(§3101.3.12). A **persistently unconscious** condition is defined as: "an irreversible condition...in which thought and awareness of self and environment are absent"(§3101.3.7). An **end-stage condition** is defined as: "a condition...which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which...treatment would be medically ineffective"(§3101.3.4).*

Advance Directive for Health Care

2. I have chosen *not* to complete the Directive at this time, but I *do* want to complete a comprehensive Health Care Power of Attorney (*skip to page 5*):

   Signature: _____ Date: _____

   OR:

3. 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. I thus do hereby declare:

I. Living Will Declaration:

4. If 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 Advance Directive Act*, to follow my instructions as set forth below.

5. *If I have a terminal Condition*:
   If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:
   (*initial only <u>one</u> option*)

   _____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

   _____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

   _____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

   _____ See my more specific instructions in paragraph (4) below. .

6. *Regarding a 'persistently unconscious' condition*:
   If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:
   (*initial only <u>one</u> option*)

   _____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

   _____I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

   _____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

   _____ See my more specific instructions in paragraph (4) below. .

7. *Regarding an 'end-stage' condition*:

If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective, then:

(*initial only <u>one</u> option*)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ See my more specific instructions in paragraph (4) below.

8. *Other Directive Instructions*:

Other instructions regarding providing, withholding or withdrawing treatment (including artificially administered nutrition and hydration) in terminal, persistently unconscious, end-stage, and/or any other condition(s):

I also direct that: _____

SECTION II:
MY APPOINTMENT OF MY HEALTH CARE PROXY
with Medical Care and Other Instructions

10. If 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 Advance Directive Act*, to follow the instructions of:

    Name of Proxy: _____
    Address: _____
    Telephone: Home:_____ Work:_____
    Cell Phone or Pager: _____ E-mail: _____

    ~~ whom I appoint as my health care proxy.

11. If my health care proxy is unable or unwilling to serve, I appoint:

    12. **Name of Alternate Proxy #1:**_____
    Address: _____
    Telephone: Home:_____ Work:_____
    Cell Phone or Pager: _____ E-mail: _____

    13. **Name of Alternate Proxy #2:**_____
    Address: _____
    Telephone: Home:_____ Work:_____
    Cell Phone or Pager: _____ E-mail: _____

    ~~ as my alternate health care proxy(ies), to serve alone and successively (not jointly), and vest them with the same authority.

14. 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 and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections, or as I have indicated below:

    (*initial only <u>one</u>*)

    _____ I want <u>my written instructions</u> to be explicitly followed.
    _____ I want <u>my agent</u> to have final authority in any and all decisions.
    _____ I want my written instructions to be followed <u>*except*</u> where my agent believes <u>unusual or unforseen circumstances</u> may have limited the intent of my written instructions.

SECTION III:
ANATOMICAL GIFTS

15. I direct that at the time of my death my entire body, or the body organs and/or body parts designated below, shall be donated for purposes of:

(*initial all that apply*)

_____ transplantation
_____ therapy
_____ advancement of medical science or research or education
_____ advancement of 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 brain, including the brain stem. If I *initial* the line(s) below, I specifically donate as indicated:

a) _____ My entire body (*note: you must call your local donor program to arrange for this well in advance if this is your desire*).

OR,

b) _____ Any needed organs and tissues.

OR,

c) _____ Only those organs and tissues I have *initialed* below:

_____ Lungs	_____ Liver
_____ Pancreas	_____ Heart
_____ Kidneys	_____ Brain
_____ Skin	_____ Bones/marrow
_____ Blood/fluids	_____ Tissues
_____ Arteries	_____ Eyes/corneas

IV. General Provisions:

16. I understand that I must be eighteen (18) years of age or older to execute this form.
17. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
18. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

19. In the absence of my ability to give directions regarding the 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 choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
20. This advance directive shall be in effect until it is revoked.
21. I understand that I may revoke this advance directive at any time.
22. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
23. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
24. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

25. Signed this _____day of _____, 20_____
(*Do not sign until in the presence of two qualified witnesses, below*)

26. Signature: _____

Printed Legal Name: _____

Date of Birth: _____

Residence Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

Witnesses:

We declare that we are at least eighteen (18) years of age or older, not related to the principal, and shall not inherit from him or her. This advance directive was signed in our presence:

57. 1st Witness: _____

Printed Name: _____

Address: _____

58. 2nd Witness: _____

Printed Name: _____

Address: _____