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:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~

Statutory Advance Directive

For

Oregon Residents

Statutory Form
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Oregon Residents

Statutory Form
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 Oregon 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 Oregon state legislature has provided a statutory-format advance directive (i.e., found within the state's statutes), including both a Health Care Instruction (living will) and a Health Care Representative appointment. Each is designed for use by the general public. As the content of these documents was designed by your state government, each is in full compliance with all applicable statutes and laws.

There is an introduction that 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:

*To complete the 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.*

OREGON ADVANCE DIRECTIVE

and Personal Instructions

(*Pursuant to Oregon Revised Statutes, Chapter 127; §127.505 to §127.660*)

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A:
IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

1. 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*)

2. 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. You can write in this document 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*)

3. 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

4. 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.

5. **Print your NAME, BIRTH DATE AND ADDRESS here**:
   Name: _____ Birth Date: _____
   Address: _____
   _____

Unless revoked or suspended, this advance directive will continue for:
[**Compare with "Part B" Addendum, #37*]

6. (*INITIAL ONE*): _____ My entire life; ***OR***: _____ Other period (_____*Years*)

PART B:
APPOINTMENT OF HEALTH CARE REPRESENTATIVE

7. **I appoint**: _____
   ~~ as my health care representative.

8. **My representative's address is**: _____
   _____
   and telephone number is _____

9. **I appoint**: _____
   ~~ as my *alternate* health care representative.

10. **My alternate's address is**: _____
    _____
    and telephone number is _____

11. **I authorize** my representative (or the 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.

12. **Limits.** *Special Conditions or Instructions*:

_____
_____
_____

(*INITIAL IF THIS APPLIES*):

13. _____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

14. Intent to Complete the "Part B Addendum" (below) as "special conditions or instructions": (*INITIAL ONE*):

_____ I have additional Representative instructions in the Addendum, below.

OR,

_____ I have chosen *not* to complete a Representative ("Part B") Addendum at this time, but I *do* wish to continue and complete the Oregon statutory directive.

15. **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*:

16. _____ 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*.)

17. **Tube Feeding**.

One sort of life support is food and water supplied artificially by medical devices, known as tube feeding.

(*INITIAL IF THIS APPLIES*):

18. _____ 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*.)

19. **Date**: _____

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE:

20. _____

(*Signature of person making appointment*)

PART C:
HEALTH CARE INSTRUCTIONS

21. 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 22 to25 below, or you may use the general instruction provided by Item 26.

    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:

22. **Close to Death**:
    If I am close to death and life support would only postpone the 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.

23. **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.

24. **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.

25. **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.

26. **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 22 to 25 above.

27. **Additional Conditions or Instructions**:

_____

_____

_____

(***Insert description of what you want done***.)

28. 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.

29. SIGN HERE TO GIVE INSTRUCTIONS

30. _____
(*Signature*)

31. _____
(*Date*)

PART D:
DECLARATION OF WITNESSES

32. 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 an attending physician.

Witnessed By:

33. _____ _____
(*Signature of Witness*) (*Date*)

_____
(*Printed Name of Witness*)

34. _____ _____
(*Signature of Witness*) (*Date*)

_____
(*Printed Name of Witness*)

35. *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

36. 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.

37. _____ _____
(*Signature of Health Care Representative*) (*Date*)

_____
(*Printed name*)

38. _____ _____
(*Signature of Alternate Health Care Representative*) (*Date*)

_____
(*Printed name*)

39. INDIVIDUALS AND INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
(877) 559-0527
www.lifecaredirectives.com