Advance Directive

Making your own health care decisions.

I,______, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. 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 terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures 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 () do not want cardiac resuscitation.
- I () do () do not want mechanical respiration.
- I () do () do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
- I () do () do not want blood or blood products.
- I () do () do not want any form of surgery or invasive diagnostic tests.
- I () do () do not want kidney dialysis.
- I () do () do not want antibiotics.

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

Other instructions:

I () do () do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable)

Name and address of substitute surrogate (if surrogate designated above is unable to serve):



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I made this declaration on theday of (month, year).
Declarant's signature:
Declarant's address:
The declaration or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence.
Witness' signature:
Witness' address:
Witness' signature:
Witness' address:
Holy Redeemer HealthCare. HomeCare. LifeCare.