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Legal Forms & Services

FirstName LastName

OREGON
HEALTH CARE DIRECTIVE

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in Oregon

After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Option 2: Notary Only

1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

Designation of a health care representative to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care representative should act in my best interest.

Health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

1. ABOUT ME

Name: FirstName LastName

Date of Birth: 08/05/2024

Telephone: 1111111111

Address: 111 Street Address City, Oregon 11111

Email: emailaddress@email.com

2. MY HEALTH CARE REPRESENTATIVE

I choose the following person as my health care representative to make health care decisions for me if I cannot speak for myself.

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Oregon 11111

Phone: 1111111111

Email: emailaddress@email.com

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 health care representative's appointment.

First Alternate Health Care Representative:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Oregon 11111

Phone: 1111111111

Email: emailaddress@email.com

3. HEALTH CARE INSTRUCTIONS

A. MY HEALTH CARE DECISIONS:

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 to say more about what kind of care you want or do not want: I do not wish to say more at this time.

B. WHAT MATTERS MOST TO ME AND FOR ME

This is what you should know about what is important TO me about my life: I do not wish to state what is important TO me at this time.

This is what I value the most about my life: I do not wish to state what I value at this time.

This is what is important FOR me about my life: I do not wish to state what is important FOR me at this time.

I do not want life-sustaining procedures if I cannot 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: I do not wish to state activities at this time.

If you want to say more to help your health care representative understand what matters most to you, write it here: I do not wish to say more at this time.

C. MY SPIRITUAL BELIEFS

More about spiritual or religious beliefs: I do not wish to state more about spiritual or religious beliefs at this time.

4. MORE INFORMATION

A. LIFE AND VALUES

More about life, beliefs, and values: I do not wish to state more about life, beliefs, and values at this time.

B. PLACE OF CARE

More about preferences for where to receive care or not receive care: I do not wish to state more about place of care at this time.

SIGNATURES

This document must be signed and dated by me. It also must either be verified by two witnesses (Option 1) OR a notary public (Option 2). It must be signed and dated when it is witnessed or verified. My health care representative should also sign this document.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: _____

Date signed: _____

If I cannot sign my name, I ask the person named below to sign for me.

Signature: _____

Printed Name:_____

TWO WITNESSES (OPTION 1)

Witness One. In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not the principal's attending physician or health care provider.
- I am not named as a health care representative or an alternate health care representative in this document.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two. In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not the principal's attending physician or health care provider.
- I am not named as a health care representative or an alternate health care representative in this document.

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

_____

Witness Two Phone: _____

OR

NOTARY PUBLIC (OPTION 2)

In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Notary Public Signature: _____

Commission Expiration Date: _____

ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE

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

Health Care Representative Signature: _____

Date: _____