

INSTRUCTIONS

**OKLAHOMA
ADVANCE DIRECTIVE FOR
HEALTH CARE**

**PRINT YOUR
NAME**

I, _____,
(name)

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:

LIVING WILL

I. LIVING WILL

a. 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 Rights for the Terminally Ill or Persistently Unconscious Act, to withhold or withdraw treatment from me under the circumstances I have indicated below by my signature. I understand that I will be given treatment that is necessary for my comfort or to alleviate my pain.

b. If I have a terminal condition:

(1) I direct that life-sustaining treatment shall be withheld or withdrawn if such treatment would only prolong my process of dying, and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

(signature)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) that will only prolong the process of dying from an incurable and irreversible condition is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

(signature)

**TERMINAL
CONDITION**

**SIGN ALL
STATEMENTS
THAT REFLECT
YOUR WISHES**

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

(3) I direct that (add other medical directives, if any)

**PERSISTENTLY
UNCONSCIOUS**

(signature)

**SIGN ALL
STATEMENTS
THAT REFLECT
YOUR WISHES**

c. If I am persistently unconscious:

(1) I direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

(signature)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) for individuals who have become persistently unconscious is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

(signature)

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

(3) I direct that (add other medical directives, if any)

(signature)

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

d. Other directions:

(signature)

**HEALTH
CARE PROXY**

II. MY APPOINTMENT OF MY HEALTH CARE PROXY

a. 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 Rights of the Terminally Ill or Persistently Unconscious Act to follow the

instructions of _____,
(name of health care proxy)

whom I appoint as my health care proxy. If my health care proxy is unable or

unwilling to serve, I appoint _____
(name of alternate health care proxy)

as my alternate health care proxy with the same authority. 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 can be made by my health care proxy or alternate health care proxy only as I indicate in the following sections.

**PRINT THE
NAME OF YOUR
HEALTH CARE
PROXY AND
ALTERNATE**

**SIGN ALL
STATEMENTS
THAT REFLECT
YOUR WISHES**

b. If I have a terminal condition:

(1) I authorize my health care proxy to direct that life-sustaining treatment be withheld or withdrawn if such treatment would only prolong my process of dying and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

(signature)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition (food) or hydration (water) will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding of artificially administered nutrition and hydration.

(signature)

(3) I authorize my health care proxy to (add other medical directives, if any)

(signature)

c. If I am persistently unconscious:

(1) I authorize my health care proxy to direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

(signature)

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

**PERSISTENTLY
UNCONSCIOUS**

**SIGN ALL
STATEMENTS
THAT REFLECT
YOUR WISHES**

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition (food) and hydration (water) will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding and withdrawal of artificially administered nutrition and hydration.

(signature)

(3) I authorize my health care proxy to (add other medical directives, if any):

(signature)

III. ANATOMICAL GIFTS

I direct that at the time of my death my entire body or designated body organs or body parts be donated for the purpose of transplantation, therapy, advancement of medical or 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. I specifically donate:

- My entire body; or
- The following organs or body parts
 - lungs, liver, pancreas
 - heart, kidneys, brain,
 - skin, bones/marrow,
 - bloods/fluids, tissues,
 - arteries, eyes/cornea,lens,
 - glands, other_____

(signature)

ADD PERSONAL INSTRUCTIONS (IF ANY)

ANATOMICAL GIFTS

CHECK THE BOX(ES) THAT BEST REFLECTS YOUR WISHES REGARDING ORGAN DONATION

SIGN YOUR NAME

**CONFLICTING
PROVISION**

**IF YOU WANT
YOUR PROXY'S
DECISIONS TO
TAKE
PRECEDENCE,
INDICATE HERE
AND SIGN YOUR
NAME**

IV. CONFLICTING PROVISION

I understand that if I have completed both a living will and have appointed a health care proxy, and if there is a conflict between my health care proxy's decision and my living will, my living will shall take precedence unless I indicate otherwise:

(signature)

**OTHER
PROVISIONS**

V. OTHER PROVISIONS

**YOU AND YOUR
WITNESSES
MUST SIGN THE
DOCUMENT ON
THE NEXT PAGE**

a. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this advance directive shall have no force or effect during the course of my pregnancy.

b. 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 refuse medical or surgical treatment including, but not limited to, the administration of any life-sustaining procedures, and I accept the consequences of such refusal.

c. This advance directive shall be in effect until it is revoked.

d. I understand that I may revoke this advance directive at any time.

e. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

f. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

**SIGN AND DATE
YOUR
DOCUMENT AND
PRINT YOUR
CITY, COUNTY
AND STATE OF
RESIDENCE**

Signed this _____ day of _____, 20 _____.

(signature)

(city, county and state of residence)

**WITNESSING
PROCEDURE**

This advance directive was signed in my presence.

(signature of witness)

(address)

(signature of witness)

(address)

**YOUR
WITNESSES
SIGN HERE AND
PRINT THEIR
ADDRESSES**