Oregon Advance Directive for Health Care

This **Advance Directive form** allows you to:

- Share your values, beliefs, goals and wishes for health care if you were not able to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes.

It is best to complete this entire form.

- Please use the Advance Directive User's Guide to help you fill out this form. The Guide answers questions you might have.
- In Sections 1, 2, 5, 6, and 7 you appoint a health care representative.
- In Sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in the User's Guide.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative. If you do not have an effective health care representative appointment and become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635(2).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

- If you have completed an advance directive in the past, this new advance directive will replace any older directive.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
- If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expressesyour desire to revoke it.
- In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

1. ABOUT ME

Name:______________________________ Date of Birth: ______________________

Telephone Numbers: (Home)____________ (Work)______________ (Cell) __________

Address: ____

Email: ____

2. MY HEALTH CARE REPRESENTATIVE.

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

Name:______________________________ Relationship: ______________________

Telephone Numbers: (Home)____________ (Work)______________ (Cell) __________

Address: ____

Email: ____

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:______________________________ Relationship:______________________

Telephone Numbers: (Home)____________ (Work)______________ (Cell) __________

Address:____

Email: ____

Second alternate health care representative:

Name:______________________________ Relationship:______________________

Telephone Numbers:(Home)____________ (Work)______________ (Cell) __________

Address:____

Email: ____

3. My Health Care Instructions

This section is the place for you to express your wishes, values and goals for care. Your instructions provide guidance for your health care representative and health care providers.

You can direct your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

A. There are three situations below for you to **express your wishes**. They will help you think about the kinds of life support decisions your health care representative could face. For each, choose the one option that most closely fits your wishes.

1. Terminal Condition

This is what I would want if…

- I had an illness that could not be cured or reversed
  AND
- My health care providers believe it would result in my death within six months, regardless of any treatments.

Initial one option only**.**

________ **I would want** to try all available treatments to sustain my life, such as using feeding tubes, IV fluids, kidney dialysis and breathing machines.

________ **I would want** to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. **I would not want** other treatments to sustain my life, such as kidney dialysis and breathing machines.

________ **I would not want** treatments to sustain my life, such as using feeding tubes, IV fluids, kidney dialysis or breathing machines. **I would want** to be kept comfortable and be allowed to die naturally.

________ **I would want** my health care representative to decide for me. This would be after they talk with my health care providers and take into account the things that matter to me. I have expressed what matters to me in Section B below.

2. Advanced Progressive Illness

This is what I would want if…

- I had an illness that was in an advanced stage
  AND
- My health care providers believe it would not improve and would very likely get worse over time and result in death
  AND

- My health care providers believe I would likely never be able to:
    - Communicate
    - Swallow food and water safely
    - Care for myself
    - Recognize my family and other people

Initial one option only.

________ **I would want** to try all available treatments to sustain my life, such as using feeding tubes, IV fluids, kidney dialysis and breathing machines.

________ **I would want** to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. **I would not want** other treatments to sustain my life, such as kidney dialysis and breathing machines.

________ **I would not want** treatments to sustain my life, such as using feeding tubes, IV fluids, kidney dialysis or breathing machines. **I would want** to be kept comfortable and be allowed to die naturally.

________ **I would want** my health care representative to decide for me. This would be after they talk with my health care providers and take into account the things that matter to me. I have expressed what matters to me in Section B below.

3. Permanently Unconscious

This is what I would want if…

- I were not conscious
  AND
- It my health care providers believe it would be very unlikely that I would ever become conscious again.

Initial one option only.

________ **I would want** to try all available treatments to sustain my life, such as using feeding tubes, IV fluids, kidney dialysis and breathing machines.

________ **I would want** to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. **I would not want** other treatments to sustain my life, such as kidney dialysis and breathing machines.

________ **I would not want** treatments to sustain my life, such as using feeding tubes, IV fluids, kidney dialysis or breathing machines. **I would want** to be kept comfortable and be allowed to die naturally.

________ **I would want** my health care representative to decide for me. This would be after they talk with my health care providers and take into account the things that matter to me. I have expressed what matters to me in Section B below.

You may write in this box or attach pages to say more about what kind of care you would want or not want.

B. **My Quality of Life:**

A terminal condition or advanced illness may put severe limits on what a person can do and how they feel. Think about what gives meaning to your life. Think about the things that are really important for you to have quality of life. Then answer the statement below.

I would not want life sustaining measures if I could not do these things again:

Initial all that apply.

____ Communicate with family, friends and others.

____ Be free from long-term severe pain and suffering.

____ Know who I am and who I am with.

____ Live without being hooked up to machines.

____ Participate in activities that have meaning to me.

If you want to say more about quality of life, you may write it here. (Examples of things you might want to do are: feed and bathe yourself, be able to live on your own, think for yourself and make your own decisions).

C. My Spiritual Beliefs

Do you have spiritual or religious beliefs you want your health care representative and those taking care of you to know? They can be rituals, sacraments, denying blood product transfusions and more.

You may write in this box or attach pages to say more about your spiritual or religious beliefs.

4. More Information

Use this section if you want your health care representative and health care providers to have more information about you.

A. Below you can **share about your life and values.** This could help your health care representative and health care providers make decisions about your health care. This might include family history, experiences with health care, cultural background, career, social support system, and more.

You may write in this box or attach pages to say more about your life, beliefs and values.

B. **Place of care**

If there is a choice about where you receive care, what would you prefer? Are there places you would want or not want to receive care? (For example, a hospital, a nursing home, a mental healthfacility, an adult foster home, assisted living, your home.)

You may write in this box or attach pages to say more about where you would prefer to receive care on not receive care.

C. You may attach to this form **other documents you think would be helpful** to your health care representative and health care providers. What you attach will be part of your Advance Directive.

You may list documents you have attached in this box.

D. **Inform others**

You can allow your health care representative and health care providers to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name	Relationship	Phone	Email

5. MY SIGNATURE.

My signature:____DATE: _______________________

6. WITNESS.

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of _____________________

County of ____________________

Signed or attested before me on____________________, 2_____, by __________________________.

Notary Public – State of ___________________

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or
acknowledged the person's signature on the document in my presence and appears to be not under duress
and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Witness Name (print): ____

Signature:______________________________Date: ____________________

Witness Name (print): ____

Signature:______________________________Date: ____________________

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.

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

Health care representative:

Printed name: ____

Signature or other verification of acceptance: _____________________________

Date: _____________________

First alternate health care representative:

Printed name: ____

Signature or other verification of acceptance: _____________________________

Date: _____________________

Second alternate health care representative:

Printed name: ____

Signature or other verification of acceptance: _____________________________

Date: _____________________

Your Guide for the Oregon Advance Directive

This Guide answers questions many people have about the Advance Directive.

What is the purpose of the Oregon Advance Directive?
It is a legal form. It lets you:

1. Write down your goals and wishes for medical care in certain situations.

2. Appoint a person to make your health care decisions if you cannot make them for yourself.

Who is the form for?
The form is for adults 18 years and older who live in Oregon.

What is a health care representative and what is their role?
This is the person you choose to make your health care decisions if you cannot make them for yourself. They do this only if health care providers conclude you are not able to make health care decisions for yourself.

It is your health care representative's job to be consistent with your wishes, values, and goals. Talk with them about your wishes. You can use your Advance Directive to start these talks.

What sections does the Oregon Advance Directive have?
It has 7 sections. Here are more details for you.

Appoint a health care representative – See Sections 2 and 7
This is where you appoint at least one health care representative. This form allows you to appoint up to three. They are:

- A primary health care representative,
- A first alternate,
- A second alternate.

The health care representative you choose can NOT be your health care provider or the owner, operator, or employee of the health care facility where you are getting care.

- Each health care representative must agree to act in this role and accept the appointment in Section 7.

- Only one health care representative can represent you at a time. If your primary cannot serve, the task will pass to the first alternate, then to the second.

- Make sure your representatives have permission to see your medical records. Call your health care provider's office to ask how to arrange this.

- If you do not appoint a health care representative, a decision maker will be assigned. This is stated in Oregon's Advance Directive law.

Your health care instructions - See Section 3
This is the place for you to express your wishes and values.

- It has questions to help you talk with your health care representative. It provides guidance to them and your health care providers.

- Your answers to these questions can help your health care providers recommend care that aligns with your wishes. This is the case even if you have not chosen a health care representative.

Extra information – See Section 4
This is where you can add extra information to guide your care.

- Use this if you want your health care providers and representative to know more about your wishes, including choices about where you will receive care. Or use this if you want your providers and representative to know why you have certain wishes.

- These might be:
    - Documents you have written that express your values,
    - Forms you have filled out from other sources (such as Five Wishes),
    - Any other information you want to share.
- There is a place where you can list people who your health care representative and health care providers can talk to about your health status and care. These people are not allowed to make any decisions about your care. Only your health care representative can make decisions about your care.

Legal requirements for a valid Oregon Advance Directive – See Sections 5, 6, and 7
To be legal and valid:

- It must list your name, date of birth, address and other contact information.
    - You must sign and date it.

- It must list the name, address and other contact information for each health care representative.
    - Each of them must accept the role, and sign or agree by electronic or verbal means.

- *Either:*
    - Two adult witnesses must sign it (neither can be your health care representatives or your health care provider) ***or,***
    - A Notary must sign it.

What if I do not fill out all the sections?
It is best to fill out all sections of the form. Still, you may choose to fill out only certain sections.

- Your wishes in sections 3 and 4 can guide your health care providers to recommend care. This is the case even if you do not choose a health care representative.

- Your Advance Directive will be valid as long as your representative has accepted in Section 7. This is the case even if you do not express your wishes.

What does the Oregon Advance Directive *not* cover?
It is *not* a medical order. A medical order turns a person's wishes into action. The Oregon Advance Directive is a form to express your wishes.

What is a POLST?
POLST stands for the Oregon Portable Orders for Life Sustaining Treatment. It is a medical order. It is filled out and signed by a health care provider. You can talk with your health care provider about the treatments you do and do not want. If it is appropriate, they will complete and sign a POLST for you.

What is the difference between the Oregon Advance Directive and the POLST?

The Advance Directive and the POLST are really different. Still, it's easy to confuse the two. This t shows the differences.

	Advance Directive	**POLST** (stands for Portable Order for Life Sustaining Treatment
Who is it for?	All people 18 years and older.	People with a serious illness or who are very old and frail
What kind of document is it?	It is a legal document.	It is a medical order.
Who signs it?	You fill it out and sign it. Your signature must be verified by a Notary Public or two witnesses. Your health care representative also signs it.	Your health care provider fills it out with your input. Then signs it.
Do I need a lawyer?	No.	No.
Who keeps the form?	You keep the original where loved ones can find it. You give a copy to your health care representative and your health care provider.	Your health care provider's office keeps it and enters it into the electronic Oregon POLST Registry. They give you a copy. You can post it at home in a place where it is easy to find, (like tacked to the refrigerator).

Can I change the form if I change my mind?	Yes. You can tear up the old one. Then write a new one where loved ones can find it. You give a copy to your health care representative and your health care provider.	Yes. You can ask for an appointment with your health care provider to change it.
What if there is a medical emergency and I cannot speak for myself?	Your health care representative speaks for you and honors your wishes.	The ambulance staff, hospital staff and health care providers look for the medical orders in the electronic data base and follow them.

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Can people have an Advance Directive *and* a POLST?
Yes. As people get sicker, they often have both. The Oregon Advance Directive is a form to express your wishes. A POLST is a medical order turns a person's wishes into action.

How often should I review my Advance Directive?
Your views may change over time. If your goals and wishes change, complete a new one.

Review and update your Advance Directive when any of the "Six **Ds**" occur:

- **D**ecade - When you start each new decade of your life.
- **D**eath - When a loved one or a health care representative dies.
- **D**ispute - When a loved one or health care representative does not agree with your wishes.
- **D**ivorce - When divorce (or annulment) happens.
  - If your ex-spouse or ex-domestic partner is your representative, your Advance Directive is no longer valid.
  - You must complete a new Advance Directive. This is the case even if you want your ex-spouse or ex-partner to remain your representative.
- **D**iagnosis - When you are diagnosed with a serious illness.
- **D**ecline - When your health gets worse or when you are not able to live on your own.

What should I do if I complete a new Advance Directive?
If you complete a new form, let these people know. Also, give them a new copy.

- Your health care representatives
- Your health care providers
- Any other person who has a copy of your Advance Directive

What should I do after I complete my Advance Directive?

1. Talk to your health care representative about your goals and your wishes for future health care. Make sure they feel able to do this important job for you. Give them a copy of your Advance Directive.

2. Talk to your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care representative is. Also make sure they know what your wishes are.

3. Give a copy to your health care provider. Make sure they know what your wishes are.

4. Keep a copy of your Advance Directive where it is easy to find.

5. Fill out the card at the bottom of this Guide. Keep it in your wallet.

Are there other forms that would help me?
You may find these forms helpful.

- Dementia decisions https://dementia-directive.org
- POLST https://oregonpolst.org/patientfamilyresources

Complete the card below, fold it, and keep it in your wallet.

I have an Advance Directive **My information** My Name: ____________________ Date: ____________________ My Address: ____________________ City, State, Zip: ____________________ Phone:____________________ Date of Birth: ____________________ Email:____________________	**My Health Care Representative:** Name: ____________________ Address: ____________________ City/State/Zip: ____________________ Phone(s): ____________________ Email: ____________________ *** List alternate health care representatives on opposite side.*