

Advanced Directive Planning

At Salem Clinic, we continually strive to provide complete healthcare. An important part of this is planning ahead for the type of care you would want in the event that you were not able to make those decisions for yourself. This information may never be needed, but it is important to consider it when you are in a stable state of health. It is also important that you have a conversation with your loved ones, so that they are aware of your healthcare wishes. You may also choose to discuss this more thoroughly with your healthcare provider, and as this could take time, it would be best to schedule an appointment for that purpose.

You may have already completed paperwork regarding end of life planning. If so, please ensure that a copy is placed on your medical record so that it is available for medical decision making, if necessary, in the future.

If you have not already completed paperwork regarding end of life planning, we encourage you to take some time and review the advanced directive form provided to you. We use the **Oregon Advance Directive for Health Care** form, which along with the **User's Guide** is available online in multiple languages at [oregon.gov](https://www.oregon.gov). When completed, this form is a legal document that allows you to designate a person to make your health care decisions if you cannot make them for yourself, as well as document your goals and wishes for your personal health care in the event that you are not able to express them in the future.

There is a section regarding your health care instructions.

1. Your wishes regarding the type of life support you would desire, if you have a terminal condition, an advanced progressive illness or are permanently unconscious.
2. What matters the most to you about your life, and if there is a situation when you would not want interventions to sustain life.
3. Your spiritual beliefs, and how they might impact your health care choices.

Once you have completed the form, you will need to have it signed by two witnesses or by a Notary. When you have completed the form, and have had it signed, please bring a copy to place in your medical record. If you would like assistance with completing the form, you can discuss this with your healthcare provider, lawyer or patient advocate.

The other form that documents information regarding a patient's desires regarding medical intervention is the **POLST** (physician order for life sustaining treatment) form. This is usually reserved for patients that are more ill or frail, and is more specific regarding treatment.

You can make changes to your Advanced Directive or POLST forms at any time. It is important to update these forms if your desires change.

Oregon Advance Directives

Planning for End of Life Decisions

This booklet contains the legal forms for the State of Oregon which allow you to express your wishes for medical care. This is called an Advance Directive because it lets you direct your health care in advance. You can use it to authorize someone you name (called your health care representative) to make health care decisions for you in the event that you are unable to speak for yourself. The Advance Directive is also the recognized way to communicate your wishes about life-sustaining procedures, whether or not you name a health care representative.

You can assure that your choices will be followed by completing the legal Advance Directive forms in this booklet. You do not have to fill out an Advance Directive. Completing an Advance Directive is the best way to assure that your wishes are respected.

If you choose to have life support stopped, you will not be abandoned. You have a right to care that assures you comfort. This type of care includes pain medication, moistening the lips, giving food and fluids by mouth, oxygen, turning the body to prevent bedsores, bathing, tending to bladder and bowel functions. Comfort care eases the dying process but does not slow it down.

The Advance Directive covers only health care decisions, and does not affect your financial affairs or medical insurance.

You should talk with your physician and family members about your choices. Give them a copy of your Advance Directive. By sharing your wishes and values, you can guide your future health care while lifting the burden of deciding from your loved ones.

It is your decision.

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

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)

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. In this document, you can write 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 Instruction)

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

- 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 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, please 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.

Print your NAME, BIRTHDATE, and ADDRESS here:

Name: _____

Birthdate: _____

Address: _____

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

_____ My entire life

_____ Other period (_____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ as my health care representative.

My representative's address is _____

and telephone number is _____ .

I appoint _____ as my alternate health care representative.

My alternate's address is _____

and telephone number is _____ .

I authorize my representative (or 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.

1. Limits.

Special Conditions or Instructions:

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE (continued)

INITIAL IF THIS APPLIES:

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

2. 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:

_____ 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.)

3. Tube Feeding.

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

INITIAL IF THIS APPLIES:

_____ 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.)

Date: _____

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

(Signature of person making appointment)

PART C: HEALTH CARE INSTRUCTIONS

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.

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

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:

1. Close to Death. If I am close to death and life support would only postpone that 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.

2. 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.

3. 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.

4. 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.

5. 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 1 to 4 above.

6. Additional Conditions or Instructions. (Insert description of what you want done.)

7. 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.

Date: _____

SIGN HERE TO GIVE INSTRUCTIONS

Signature: _____

PART D: DECLARATION OF WITNESSES

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 the 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 the attending physician.

Witnessed By:

_____ Signature of Witness	_____ Date	_____ Printed Name of Witness
_____ Signature of Witness	_____ Date	_____ Printed Name of Witness

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

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.

_____ Signature of Health Care Representative	_____ Date
_____ Printed Name	
_____ Signature of Alternate Health Care Representative	_____ Date
_____ Printed Name	