Medical Directive ("Living Will")

I understand that there may come a time when I cannot express my wishes about medical treatment. If I have a condition where my doctors believe there is little chance I will recover from my illness and that my death is likely no matter what is done, then I request that this document be taken to indicate my decisions about the following medical treatments.

I understand that these decision are not all inclusive and that if I can no longer communicate, my physician along with my patient advocate will make the most appropriate treatment decision based on what I have indicated in the following boxes.

(please mark appropriate boxes below)	Want	Don't Want
Cardiopulmonary Resuscitation (CPR) The use of drugs, artificial breathing, and electric shock to start the heart after it has stopped	❑	❑
Mechanical Breathing Breathing by a machine through a tube placed in the throat	❑	❑
Surgery Such as removing the gallbladder or part of the intestine	❑	❑
Dialysis The use of a machine to remove waste from the blood when the kidneys can no longer do that job.	❑	❑
Invasive Tests Such as using a flexible tube to look into the stomach or lungs	❑	❑
Nutrition and Hydration Food and fluid given through a tube in the veins, nose, or stomach	❑	❑
Transfusion Of blood or blood products such as platelets or plasma.	❑	❑
Antibiotics Drugs to fight infection	❑	❑
Non-invasive Tests Tests with little potential for complications or discomfort, such as blood tests or X-rays	❑	❑
Other _____	❑	❑

Patient Signature _____ Witness Signature _____

Date _____ Date _____