

Living Will Declaration

To my family, health care provider, and all those concerned with my care:

I, _____, _____ direct you to follow my wishes for care, as noted below, if I am in a terminal condition,
(Declarant/Patient) (Date of Birth)
my death is imminent, and I am unable to communicate my decisions about my medical care.

Emergent Life Support Treatment:

Life-supporting treatment means any medical procedure, device or medication to keep me alive.

I note what I want by initialing one of the treatments below:

- _____ Full Resuscitation
- _____ Resuscitation without intubation (no breathing tube)
- _____ CPR (chest compressions or cardiopulmonary resuscitation)
- _____ Chemical Resuscitation (medications only)
- _____ DNR (allow natural death)

Life-Sustaining Treatment: *Life-sustaining treatment may help to prolong my life.*

I note what I want by initialing the treatments below:

- _____ Surgery
- _____ Artificial hydration
- _____ Artificial nutrition
- _____ Feeding tube
- _____ Dialysis
- _____ Antibiotics
- _____ DNI (Do not intubate or place breathing tube)
- _____ Intubate (place breathing tube and offer respirations only)
- _____ Cardioversion (electrical shock to the heart)
- _____ Blood Transfusions
- _____ Other medical treatment as written: _____

Personal Choices beyond emergent life-support and life sustaining medical care: *(Initial your choices)*

- _____ I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even it that means I will be drowsy or sleep more than I would otherwise.
- _____ Information about options for hospice care.
- _____ I desire to die in my home if that can be done.
- _____ The following person knows my funeral desires:

Dated this _____ day of _____, 20_____. _____
(Declarant/Patient)

The Declarant/Patient: _____
voluntarily signed this document in my presence.

Witness: _____
(Print Name): _____
Date: _____
Address: _____

Notary Public: _____
My Commission Expires _____ Seal

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