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
(Declarant/Patient) *(Date of Birth)*

terminal condition, 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 if that 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