Living Will Declaration

Patient Name PRINT: _____
Last First Middle Initial

Date of Birth: _____

Gender: _____

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

in a terminal condition, my death is imminent, and I am unable to communicate my decisions about my medical care.

Cardiopulmonary Resuscitation (CPR):

Providing chest compressions and artificial breathing to someone after the heart has suddenly, and unexpectedly, stopped**.**

Initial the box beside the statement that indicates the care you wish to receive.

☐ I want CPR attempted unless my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

☐ I do **NOT** want CPR attempted if my heart stops. To the extent possible, I want to allow a natural death.

Instructions Regarding Life-Prolonging Treatments

Initial the box beside the type of care you want:

I understand if I do not initial a box then that type of care will NOT be given to me, unless my doctor believes it to be in my best interest..

☐ IV Hydration – *Intravenous fluid to provide hydration.*

☐ Respirator / Ventilator – *A machine that helps you take breaths if you cannot do it on your own.*

☐ Surgery – *Invasive procedure needed to manage situation.*

☐ Artificial Nutrition and Feeding Tubes – *Nutrition delivered through tubes inserted into the nose or veins or stomach.*

☐ Dialysis – Equipment that helps remove fluid and waste products from blood when kidneys are not working.

☐ Antibiotics – *A medicine that inhibits growth or destroys microorganisms.*

☐ Blood Transfusions – *Donated blood provided by IV to sustain life.*

☐ Cardioversions – *A procedure to restore normal heart rhythm.*

Other instructions

_____

_____

_____

Pain and Comfort

Initial the box beside the statement that indicates the care you wish to receive.

☐ If I reach a point where efforts to prolong my life are stopped, I still want medical treatments and nursing care that will make me comfortable.

The following are important to me for comfort (If you don't write specific wishes, your physician and nurses will provide the standard of care according to accepted medical standards):

_____

_____

_____

Other instructions or limitations I want my health care agent to follow:

_____

_____

_____

When I am nearing my death and cannot communicate, I want my friends and family to know I have the following thoughts and feelings:

_____

_____

_____

If I am nearing my death, I want the following:

List the type of care, ceremonies, etc. that would make dying more meaningful for you.

_____

_____

_____

Person or people I want my health care agent to include when making health care decisions:

I ask that my health care agent make a reasonable effort to include the following person or people in my health care decision if there is time, but I understand my health care agent will have the final authority to make decisions about my care:

_____

Spirituality and/or Religious Affiliation

Initial the box beside the statement that indicates the care you wish to receive.

I am of the _____ faith and am a member of the _____ congregation, parish, synagogue, or worship group in (city) _____. The telephone number of the congregation, parish, synagogue, or worship group is: _____.

☐ Please attempt to notify someone there if I am unable to give authorization to do so.

☐ I do **NOT** want anyone contacted.

Upon My Death

After my death the following are my instructions. I ask that my next of kin and physician follow these requests if possible:

_____

_____

- **Donation of my Organs or Tissue (Anatomical Gifts)**

Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves.

Initial the box beside the one statement you agree with.

☐ After I die, I wish to donate my organs and tissue.

☐ I do NOT wish to donate my organs or tissue.

Making the Document Legal

The document must be signed and dated in the presence of two witnesses who meet the qualifications explained below.

Patient Signature

I am thinking clearly, I agree with everything that is written in this document, and I have completed this document willingly.

Patient Signature: _____ Date: _____

If I cannot sign my name, I ask the following person to sign for me _____.

Signature of the person who I asked to sign this document for me _____.

Document can be completed with two (2) adult witnesses or a notary.

Witness Number One:

Witness Name PRINT: _____

Witness Signature: _____ Date: _____ Time: _____

Address: _____

City: _____ State/Zip: _____

Witness Number Two:

Witness Name PRINT: _____

Witness Signature: _____ Date: _____ Time: _____

Address: _____

City: _____ State/Zip: _____

Notary:

State of South Dakota)
) ss
County of _____)

On this _____ day _____ ,20 _____ , _____, known to me or satisfactorily proven to be the person named above, personally appeared before me, a Notary Public with the State of South Dakota, and acknowledged that he or she executed the same for the purposes stated herein.

Notary Public _____

Seal

My commission expires _____