OREGON
Advance Directive
Planning for Important Health Care Decisions

Caring Info
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Info, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Info updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR OREGON ADVANCE DIRECTIVE

This packet contains a legal document, the **Oregon Advance Directive,** that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You can complete Part B, Part C, or both, depending on your advance-planning needs. You must complete Part D.

Part A of your Oregon Advance Directive contains important information that you should read before completing your document.

Part B of your Oregon Advance Directive is the **Appointment of Health Care Representative**. This section lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The appointment of health care representative is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your appointment of health care representative goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part C of your Oregon Advance Directive is for **Health Care Instructions**. This section functions as a living will. It lets you state your wishes about medical care in the event that you can no longer make your own medical decisions and you are close to death, permanently unconscious, have an advanced progressive illness, or if life support would cause you extraordinary suffering.

Your health care instructions go into effect when your doctor determines that you are no longer able to make or communicate your health care decisions, and a condition you have given instructions on arises.

Part D contains the signature and witnessing provisions so that your document will be effective.

Following your advance directive is an **Oregon Organ Donation Form**.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: Oregon law requires you to use state-mandated forms for your Appointment of Health Care Representative and Health Care Instructions. This packet contains the state-mandated forms with no modifications other than the addition of the instructions in the grey bar on the left side of each page. If you have health care planning needs that are not covered by these forms, you should talk to an attorney about your options.

Note: This document will be legally binding only if the person completing it is a competent adult (at least 18 years old), an emancipated minor, or is married.

COMPLETING YOUR OREGON ADVANCE DIRECTIVE

How do I make my Oregon Advance Directive legal?

The law requires that you sign your document, or direct another to sign it. To be valid, your document must be either witnessed and signed by at least two adults; or notarized by a notary public. Your witnesses cannot be your health care representative, alternate health care representative, or attending health care provider. Each witness must witness you signing the document or you acknowledging any other method by which you accepted the Advance Directive or form appointing a health care representative.

If you are a patient in a long-term care facility, one of your witnesses must be a person designated by your facility and qualified under the rules of the Department of Human Resources.

Part B of your Advance Directive (Appointment of Health Care Representative) will not go into effect until your health care representative (or alternate) sign and date the acceptance statement on page 8 of your document (Part E).

Whom should I appoint as my health care representative?

Your health care representative is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your health care representative may be a family member or a close friend whom you trust to make serious decisions. The person you name as your health care representative should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate health care representative. The alternate will step in if the first person you name as a health care representative is unable, unwilling, or unavailable to act for you.

Unless he or she is related to you by blood, marriage, or adoption, the person you appoint as your health care representative **cannot** be:

- your attending physician or an employee of your attending physician, or
- an owner, operator, or employee of a health care facility in which you are a patient or resident, unless you appointed him or her as your health care representative before your admission to the facility.

In addition, you may not appoint your parent or former guardian without a court order if you were ever removed from their custody and a court terminated your parent's parental rights or permanently removed you from your former guardian's home for safety reasons.

Should I add personal instructions to Part B of my Oregon Advance Directive?

One of the strongest reasons for naming a health care representative is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your health care representative carry out your wishes, but be careful that you do not unintentionally restrict your health care representative's power to act in your best interest. In any event, be sure to talk with your health care representative about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

If your Advance Directive includes instructions regarding withdrawal of life support or tube feeding, you may revoke your Advance Directive at any time and in any manner that expresses your intent to revoke it.

In all other cases, you may revoke your Advance Directive at any time and in any matter as long as you are capable of making medical decisions.

Your Oregon Advance Directive will automatically be revoked if you execute a new Oregon Advance Directive, unless you have specified otherwise in your document. The directions in your Advance Directive supersede any directions contained in a previous court appointment or other advance directive; and any prior inconsistent expressions of preferences with respect to health care decisions.

If you appoint your spouse as your health care representative, the appointment is automatically revoked if you petition for divorce or annulment, unless you reaffirm your health care representative's appointment in writing.

What other important facts should I know?

Your health care representative is not authorized to make health care decisions with respect to any of the following:

(1) mental health treatment,
(2) sterilization,
(3) abortion, or
(4) withholding or withdrawing life-sustaining procedures unless given authority to do so by initialing paragraph 2 in Part B of your Advance Directive.

PART A

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:

INTRODUCTION

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.

You can write in this document 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 Instructions)
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 advance 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.

PRINT YOUR NAME, ADDRESS AND DATE OF BIRTH

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, ask a lawyer to explain it to you.

INITIAL TO INDICATE WHETHER YOU WANT YOUR ADVANCE DIRECTIVE TO EXPIRE OR LAST YOUR WHOLE LIFE

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

Name _____ Birth date _____

Address _____

Unless revoked or suspended, this advance directive will continue for:
INITIAL ONE: _____ My entire life _____ Other period (_____ Years)

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PART B

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR REPRESENTATIVE

I appoint _____
(name of health care representative)
as my health care representative. My representative's relationship to me is _____. My representative's address is _____
_____,
email address is _____, and telephone number is_____.

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE REPRESENTATIVE

I appoint _____
(name of alternate health care representative)
as my alternate health care representative. My alternate's relationship to me is _____. My alternate's address_____
_____, email 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. In addition, you may not appoint your parent or former guardian without a court order if you were ever removed from their custody and a court terminated your parent's parental rights or permanently removed you from your former guardian's home for safety reasons.

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR REPRESENTATIVE'S AUTHORITY

1. LIMITS.
Special Conditions or Instructions:

_____

_____

_____

_____

_____

INITIAL IF YOU HAVE EXECUTED HEALTH CARE INSTRUCTIONS

INITIAL IF THIS APPLIES:
____ I have executed a Health Care Instruction (Part C) or Directive to Physicians. My representative is to honor it.

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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 YOU WANT YOUR REPRESENTATIVE TO MAKE DECISIONS ABOUT LIFE SUPPORT

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 YOU WANT YOUR REPRESENTATIVE TO MAKE DECISIONS ABOUT 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: _____

DATE AND SIGN HERE IF YOU ARE COMPLETING PART B

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

_____
(signature of person making appointment)

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PART C

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 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.
- 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 the moment of my death:

INITIAL ONLY ONE

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

INITIAL ONLY ONE

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:

INITIAL ONLY ONE

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

INITIAL ONLY ONE

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.

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3. ADVANCED PROGRESSIVE ILLNESS.
If I have a progressive illness that will be fatal and the illness is in an advanced stage, and I am consistently and permanently unable to communicate, 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:

INITIAL ONLY ONE

A. INITIAL ONE:
____ I want to receive tube feeding.
____ I want tube feeding only as my physician recommends.
____ I DO NOT WANT tube feeding.

INITIAL ONLY ONE

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:

INITIAL ONLY ONE

A. INITIAL ONE:
____ I want to receive tube feeding.
____ I want tube feeding only as my physician recommends.
____ I DO NOT WANT tube feeding.

INITIAL ONLY ONE

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.

INITIAL IF YOU DO NOT WANT LIFE SUPPORT FOR ANY OF THE LISTED CONDITIONS ABOVE (1-4)

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.

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES, IF NEEDED

INITIAL TO INDICATE CHOICE REGARDING ANY PREVIOUSLY EXECUTED POWERS OF ATTORNEY

DATE AND SIGN

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6. ADDITIONAL CONDITIONS OR INSTRUCTION.
(Insert description of what you want done.)

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(Attach additional pages, if needed.)

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.
____ 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

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 this 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 attending physician or attending health care provider.

Witnessed by:

_____

(signature of witness) (date)

_____

(printed name of witness)

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE. IN THE ALTERNATIVE, YOU MAY HAVE THIS DOCUMENT NOTARIZED BY A NOTARY PUBLIC IN THE STATE OR OREGON.

_____

(signature of witness) (date)

_____

(printed name of witness)

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PART E

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. 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. 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.

YOUR REPRESENTATIVE (OR ALTERNATIVE REPRESENTATIVE) MUST SIGN, DATE, AND PRINT HIS/HER NAME HERE IN ORDER FOR HIS/HER AUTHORITY TO GO INTO EFFECT

_____

(signature of health care representative) (date)

_____

(printed name)

_____

(signature of alternate health care representative) (date)

_____

(printed name)

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Courtesy of Caring Info
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

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OREGON ORGAN DONATION FORM — PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your health care representative or other agent, or your family, may have the authority to make a gift of all or part of your body under Oregon law.

_____ I do not want to make an organ or tissue donation and I do not want my health care representative or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Oregon law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:
_____
_____
_____

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

Courtesy of Caring Info
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Oregon advance directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your health care representative and alternate health care representative, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your health care representative(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Oregon document.

7. Be aware that your Oregon document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Oregon authorizes a special order, called a Physician Order for Life-Sustaining Treatment ("POLST"), that can be registered with the state to ensure your out of hospital, end of life treatment preferences are honored. We suggest you speak to your physician, or visit http://ohsu.edu/polst/programs/oregon-details.htm, if you are interested in obtaining one. **Caring Info does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

- -

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

OR donate online today: www.NationalHospiceFoundation.org/donate