

**DIRECTIONS**

Today's date.  
Your name.

Place your initials next to each item that applies. See reverse for definitions.

Place your initials next to each item you want. Mark only the items you want.

Add anything else you want to say, including procedures or treatments you do or do not want.

Your name and signature.

Both witnesses must see you sign this form at the same time. Only one witness can be a husband, wife or blood relative.

This declaration is made this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

I, \_\_\_\_\_, want to make known my decision that my dying not be artificially prolonged.

I state that, if at any time, I am mentally or physically incapacitated and:

- \_\_\_\_\_ 1) I have a terminal condition, or
- \_\_\_\_\_ 2) I have an end-stage condition, or
- \_\_\_\_\_ 3) I am in a persistent vegetative state,

and if my attending physician and another consulting physician have determined there is no reasonable medical probability of my recovery from such condition; **I direct life-prolonging procedures be withheld or withdrawn** when such treatment would only artificially prolong the process of my dying.

I want to die naturally and receive only treatment needed to keep me comfortable and control my pain.

**I want the following procedures even if they artificially prolong the process of dying:**

- \_\_\_\_\_ hydration (i.e., intravenous [IV] fluids)
- \_\_\_\_\_ nutrition (i.e., tube feedings or other means of liquid nourishment)
- \_\_\_\_\_ breathing (i.e., ventilator)

**Additional instructions (optional):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I want my Living Will to be honored by my family, authorized representative and physician. I understand that I may change my mind at any time.

**AUTHORIZATION**

I understand the importance of this declaration, and I am emotionally and mentally able to make these decisions.

\_\_\_\_\_  
**Patient Name** (please print)

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**#1 Witness Name** (please print)

\_\_\_\_\_  
**#1 Witness Signature**

\_\_\_\_\_  
**#1 Witness Address**

\_\_\_\_\_  
**#1 Witness Phone Number**

\_\_\_\_\_  
**#2 Witness Name** (please print)

\_\_\_\_\_  
**#2 Witness Signature**

\_\_\_\_\_  
**#2 Witness Address**

\_\_\_\_\_  
**#2 Witness Phone Number**



**LIVING WILL**

## CONDITIONS

Any competent adult may at any time make a living will or written declaration and direct the providing, withholding, or withdrawal of life-prolonging procedures, in the event such person develops a terminal condition, an end-stage condition, or a persistent vegetative state.

## DEFINITIONS

**informed consent:** consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

**terminal condition:** a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment can be expected to cause death.

**end-stage condition:** a condition caused by injury, disease, or illness which has resulted in severe and permanent deterioration, indicated by incapacity and complete physical dependency, and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

**persistent vegetative state:** a permanent and irreversible condition of unconsciousness in which there is:  
a.) the absence of voluntary action or cognitive behavior of any kind; b.) an inability to communicate or interact purposefully with the environment.

**life-prolonging procedure:** any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

**health care surrogate (HCS):** a person designated by an individual to make health care related decisions on their behalf. HCS may apply for public benefits to defray the cost of health care and authorize admission to, or transfer to or from, a health care facility.

You must provide a copy of this form to your health care surrogate. You may provide copies of this form to your physician, attorney, legal representative, family, friends, significant other and caregiver.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If I am not able to make decisions or express my wishes concerning medical treatment and surgical and diagnostic procedures, I appoint the following person(s) to do so for me:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

My surrogate can make health care decisions and provide, withhold, or withdraw consent on my behalf; or apply for public benefits to reduce the cost of health care; and authorize my admission to or transfer from a health care facility.

I have a living will.     Yes     No

I state that this appointment is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons so they may know who my surrogate is:

*[These persons should include your health care surrogate and at least one of the following: your physician, attorney, legal representative, family, friend, significant other or caregiver.]*

Name(s): \_\_\_\_\_

Name(s): \_\_\_\_\_

\_\_\_\_\_  
**Patient Name** (please print)

\_\_\_\_\_  
**Patient Signature**

*[Both witnesses must see you sign this form at the same time. Your health care surrogate(s) cannot be a witness. Only one witness can be a husband, wife or blood relative.]*

\_\_\_\_\_  
#1 Witness Name (please print)

\_\_\_\_\_  
#1 Witness Signature

\_\_\_\_\_  
#1 Witness Address

\_\_\_\_\_  
#1 Witness Phone Number

\_\_\_\_\_  
#2 Witness Name (please print)

\_\_\_\_\_  
#2 Witness Signature

\_\_\_\_\_  
#2 Witness Address

\_\_\_\_\_  
#2 Witness Phone Number



Good Shepherd Initially Licensed in 1984  
H O S P I C E Making the Most of Life

## DESIGNATION OF HEALTH CARE SURROGATE