PLEASE NOTE: THIS IS ONLY AN EXAMPLE OF A LIVING WILL. *THERE IS NO OFFICIAL NEW YORK STATE FORM FOR A LIVING WILL.* YOU MAY USE THIS FORM OR CHANGE IT IN ANY WAY TO EXPRESS YOUR HEALTH CARE WISHES.

ADVANCE DIRECTIVE GUIDELINES (LIVING WILL)

I, _____ have prepared these guidelines for use by my health care agent (referred to herein as "my agent"), in the event that it becomes necessary to clarify my wishes, or if any physician, nurse or representative of any hospital or health care institution is reluctant to accept the decisions made by my agent.

I wish the treatment decisions described in these guidelines to be implemented if my physician and an independent consultant agree that my clinical status fits any one of the five conditions described below or *any other condition that seems comparable*. (If there is disagreement among the physicians, my agent is instructed to consider further consultation but, ultimately, to resolve any disagreement by using his or her best judgment as to what I would want for myself.)

I wish these guidelines to be implemented if I am in a condition comparable to any of the following:

(a) I am unconscious or in a coma or persistent vegetative state with no reasonable expectation that I will regain consciousness; or

(b) I am in a so-called "minimally conscious state" or have brain damage or a brain disorder that is very unlikely to be reversible and that prevents my being able to recognize family members, communicate understandably and care for myself, even though I am conscious and might be able to survive for an extended time in such condition; or

(c) It is likely that I will never again be able to live without mechanical ventilation and/or feeding tubes (artificial nutrition and hydration); or

(d) I am suffering from an incurable and progressive disease and/or a terminal illness that interferes with my ability to engage in thoughtful treatment decision-making and/or causes me great physical or emotional/spiritual suffering; or

(e) Despite being conscious, I am in an advanced stage of dementia and, for this or any other reason, I am unable to communicate clearly, **or** to recognize my family and other people, **or** unable to care for myself **or** unable to swallow food and water safely.

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If my agent concludes, after reasonable medical consultation, that I am suffering from any of the foregoing conditions, I want a DNR order written and I wish all medication, all treatment, all **feeding by hand** and all artificial nutrition and hydration that might prolong my life to be withheld or, if already begun, to be withdrawn. Other examples of procedures I do **not** want are: antibiotics, blood transfusions, kidney dialysis and invasive diagnostic procedures; I do not want surgery, unless it is absolutely necessary to control pain. Any previously implanted cardiac devices are to be deactivated. The foregoing list is not exhaustive; it is my wish to have no procedure that would prolong my life under any of the conditions described above.

However, I do want to receive simple hygiene and measures to assure comfort, to relieve pain and allay anxiety. I would like my lips and inner surface of my mouth to be kept moistened to minimize discomfort. I would like medication for pain and/or anxiety to be administered to me in sufficient dosage and with sufficient frequency to assure **effective** palliation and symptom relief, even though such medication might shorten my life. I particularly want sedation sufficiently strong to relieve any respiratory distress that I may be suffering.

Under the conditions described above, life will have no value for me and I would want to die peacefully and quickly, avoiding a drawn-out death that would involve unnecessary suffering for me and/or for those whom I love.

I have tried to describe above the kinds of circumstances under which I would like life-sustaining treatment to be withdrawn or withheld. However, I cannot anticipate and describe every possibility, and I want my agent to be guided at all times by the principle of compassion and to demand withholding or withdrawal of life sustaining measures if my condition is comparable to the circumstances described above.

It is my wish to die at home, rather than in a hospital or other institution, provided that this does not impose an unreasonable burden on my family. If I am in a hospital, nursing home or other health care facility when my condition is judged to be as outlined above, I wish **"Do Not Resuscitate"** and **"Do Not Intubate" and "Do not hand feed"** orders to be written and I would like my agent to ascertain whether that facility will honor my wishes as set forth in these guidelines. If not, I would like to be removed from such facility and placed under hospice care in my own home or in some other setting where capable staff will provide compassionate end-of-life care in accordance with these guidelines.

It is my intention that my agent's instructions be honored by everyone, including my family, my physicians and all others concerned with my care. I expect all such persons to be legally and morally bound to act in accord with my wishes, as set forth on my behalf by my agent.

Signature_____Date_____pg. 2

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If any hospital or other institution or any physician, nurse or other health care personnel refuse to obey my wishes as set forth herein, I hereby direct my agent to commence suit against such institution and personnel for all hospital costs, drugs, medical expenses and all other damages flowing from such refusal, and I further direct my agent not to pay bills for subsequent services from any such health care provider.

Under the circumstances outlined in the preceding paragraph, I also direct that I be transferred in a timely manner from such institution to an appropriate health care institution that will agree to honor this advance directive.

I recommend, in the case of refusal by any health care institution or any physician, nurse or other health care personnel to obey my wishes as expressed here, that my agent consider one or more of the following actions: (a) the threat of **adverse publicity** in the public media; (b) **malpractice suit**, because of failure to obtain informed consent for intrusive or invasive procedures; or (c) a suit for **assault and battery**. Consult my attorney, _____ (tel_____; cell: _____)

The question may arise as to whether I may have had a change of mind. It is my direction that, absent a written revocation of this document, it must be presumed that I have not had a change of mind, no matter how much time may have elapsed between the execution of this document and its enforcement.

Upon my death, if any of my organs or tissues are sound and would be of value as transplants for other people or useful for research, I freely give my permission for such donation.

I have subscribed to this declaration in the presence of witnesses and, in a separate document, I have designated my health care agent, to whom I have communicated the decisions set forth above and upon whom I have conferred the authority to communicate these decisions to all concerned.

Unless I revoke it, this set of guidelines to my agent shall remain in effect indefinitely.

Signature_____ Date _____pg 3.

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We, whose names are hereto subscribed, declare that the person who signed all 3 pages of this document is personally known to us, appears to be of sound mind and acting of his or her own free will, and signed this document in our presence.

Witness 1:

Signature_____ Date _____

Print name_____

Address_____

Witness 2:

Signature_____ Date _____

Address_____