

## MEDICAL LIVING WILL

I, \_\_\_\_\_, direct those involved in my healthcare to implement my healthcare preferences, as indicated below, when I cannot speak for myself. My medical power of attorney is \_\_\_\_\_ and I expect that he/she will honor my wishes as stated below.

\_\_\_\_\_ I want my life to be prolonged to the greatest extent possible, i.e. with use of all available artificial life-sustaining treatments.

*If you initial this statement, do not initial any others on this page and proceed to signing the document.*

\_\_\_\_\_ I expect my doctor to administer treatments that may help me enjoy an acceptable quality of life. However, if my quality of life becomes unacceptable to me, I direct that treatments be withdrawn. My healthcare power of attorney will decide what an acceptable quality of life is for me when I can no longer speak for myself.

I always expect to be given care and treatment for pain and symptom control even when such care might make me sleepy, make me feel like not eating, slow down my breathing, or be habit-forming.

There are some procedures that I do not want.

- \_\_\_\_\_ Cardiopulmonary resuscitation (CPR), compression, shock
- \_\_\_\_\_ Assisted or mechanical ventilation (breathing machine, breathing tube)
- \_\_\_\_\_ Feeding tube
- \_\_\_\_\_ Dialysis
- \_\_\_\_\_ Antibiotics
- \_\_\_\_\_ Blood transfusions
- \_\_\_\_\_ Vasoactive agents – to control blood pressure
- \_\_\_\_\_ Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness:

**I affirm that I was present when this document was signed (marked), and I believe him/her to be of sound mind and to have completed this document voluntarily. I am an adult, not related to him/her by blood, marriage or adoption, and not an agent named in this document. I am not, to my knowledge, a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her healthcare.**

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Talk about this form and your ideas about your healthcare with the person you have chosen to make decisions for you – your doctor(s), your family and friends. Give each of them a copy of this form. You should review this form often. You may cancel or change this form at any time.

◆ Take a copy of this with you whenever you go to the hospital or on a trip ◆