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## OKLAHOMA ADVANCE DIRECTIVE

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# Advance Directive for Health Care

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This form is available in English, Spanish and Vietnamese at [okdhs.org/programsandservices/aging/legal](http://okdhs.org/programsandservices/aging/legal).

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If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

## I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

1. If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

**(Initial one option only)**

\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

\_\_\_\_\_ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

**(Initial if applicable)**

\_\_\_\_\_ See my more specific instructions in paragraph four (4).

2. If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

**(Initial one option only)**

\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

\_\_\_\_\_ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

**(Initial if applicable)**

\_\_\_\_\_ See my more specific instructions in paragraph four (4).

3. If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

**(Initial one option only)**

\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

\_\_\_\_\_ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

**(Initial if applicable)**

\_\_\_\_\_ See my more specific instructions in paragraph four (4).

4. Other.

Here you may: (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn; (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition; or (c) do both of these.

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**II. My Appointment of My Health Care Proxy**

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of:

\_\_\_\_\_, whom I appoint as my health care proxy.

If my health care proxy is or becomes unable or unwilling to serve, I appoint:

\_\_\_\_\_ as my alternate health care proxy with the same authority.

My health care proxy is authorized to make whatever health care decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

### III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

**(Initial all that apply)**

- transplantation therapy
- advancement of medical science, research or education
- advancement of dental science, research or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:

**(Initial all that apply)**

My entire body; or

The following body organs or parts:

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> lungs         | <input type="checkbox"/> liver        | <input type="checkbox"/> arteries         |
| <input type="checkbox"/> pancreas      | <input type="checkbox"/> heart        | <input type="checkbox"/> glands           |
| <input type="checkbox"/> kidneys       | <input type="checkbox"/> brain        | <input type="checkbox"/> tissue           |
| <input type="checkbox"/> skin          | <input type="checkbox"/> bones/marrow | <input type="checkbox"/> eyes/cornea/lens |
| <input type="checkbox"/> bloods/fluids | <input type="checkbox"/> tissue       | <input type="checkbox"/> other            |

### IV. General Provisions

- a. I understand that I must be eighteen (18) years of age or older to execute this form.
- b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
- c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.
- d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.

Continued on next page

- e. This advance directive shall be in effect until it is revoked.
- f. I understand that I may revoke this advance directive at any time.
- g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
- h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
- i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Residence (City, county and state)

\_\_\_\_\_  
Date of birth (Optional)

**This advance directive was signed in my presence.**

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State

\_\_\_\_\_  
City/State

**For assistance in filling out this form call (405) 522-3069.**





## **CRITICAL STEP: SHARE YOUR COMPLETED DOCUMENT!**

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**Your document is only helpful if people know where to find it when it is needed.** It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

### **WHO NEEDS A COPY OF YOUR DOCUMENT?**

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

### **HOW TO SHARE YOUR DOCUMENT**

- 1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address\*

**Create your free Cake account: [www.joincake.com/share-free](http://www.joincake.com/share-free)**

- 2) **Or, print** and provide copies to everyone who needs one

### **WHY PLAN & SHARE WITH CAKE?**

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address\*

**Create your free Cake account: [www.joincake.com/share-free](http://www.joincake.com/share-free)**

*\* Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*