Oklahoma Department of Corrections
Living Will/Advance Directive for Health Care
63 O.S. § 3101.4.

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 months:

_____ 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.

Initial only one option

_____ 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.

_____See my more specific instructions in paragraph (4) below. (Initial if applicable)

(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:

_____ 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.

Initial only one option

_____ 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.

_____See my more specific instructions in paragraph (4) below. (Initial if applicable)

(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:

_____ 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.

Initial only one option

_____ 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.

_____See my more specific instructions in paragraph (4) below. (Initial if applicable)

(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:

_____

_____

_____

_____

_____

_____

_____
Initial

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 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 medical treatment decisions I could make if I were able, except those 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.

My health care proxy acts as my agent for the purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CFR Secs. 160-164, and related provisions of law, either state or federal, and is specifically authorized by me to both give and receive information to or from health care providers, hospital staff, insurance companies and all others interested or involved in my medical care or treatment so that he/she may faithfully, fully, and competently carry out the terms of his/her role as my health care proxy, being fully informed and in the best manner possible.

III. General Provisions

a. I understand that I will be 18 years of age or older to execute this form.

b. I understand that my witnesses will be 18 years of age or older and will not be related to me and will 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 will 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 will 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.

e. This advance directive will 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) will 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.

Note: Activation for a Living Will/Advance Directive and/or Do Not Resuscitate (DNR) will never be honored in situation of self-harm or assault.

Signed this _____day of _____, 20 _____.

_____
(Signature)

_____
City of

_____
County, Oklahoma

_____
Date of birth

_____
(Optional for identification purposes)

This advance directive was signed in my presence.

_____
Witness
_____, Oklahoma
Residence

_____
Witness
_____, Oklahoma
Residence

Name
(Last, First)

DOC #