OREGON
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, an emancipated minor, or married.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR OREGON ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, the **Oregon Advance Directive,** that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Page 1 of your Oregon Advance Directive contains important information that you should read before completing your document.

Part 2 of your Oregon Advance Directive is the **Appointment of Health Care Representative**. This section lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The appointment of health care representative is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part 3 of your Oregon Advance Directive is for **Health Care Instructions**. This section functions as a living will. It lets you state your wishes about medical care in the event that you can no longer make your own medical decisions and you are close to death, permanently unconscious, have an advanced progressive illness, or if life support would cause you extraordinary suffering.

Parts 5, 6, and 7 contains the signature and witnessing provisions so that your document will be effective.

Following your advance directive is an **Oregon Organ Donation Form**.

You can complete Part B, Part C, or both, depending on your advance-planning needs. **You must complete Part D.**

How do I make my Oregon Advance Health Care Directive legal?

Oregon gives you two options. The law requires that you sign your document, or direct another to sign it. To be valid, your document must be either:

Option 1: witnessed and signed by at least two adults. Your witnesses cannot be:

- your health care representative,
- alternate health care representative,
- or attending healthcare provider.

Each witness must witness you signing the document or you acknowledging any other method by which you accepted the Advance Directive or form appointing a health care representative.

If you are a patient in a long-term care facility, one of your witnesses must be a person designated by your facility and qualified under the rules of the Department of Human Resources.

OR

Option 2: notarized by a notary public

Part B of your Advance Directive (Appointment of Health Care Representative) will not go into effect until your health care representative (or alternate) sign and date the acceptance statement on page 8 of your document (Part E).

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You can appoint a second person as your alternate health care representative. The alternate will step in if the first person you name as a health care representative is unable, unwilling, or unavailable to act for you.

Unless he or she is related to you by blood, marriage, or adoption, the person you appoint as your health care representative **cannot** be:

- your attending physician or an employee of your attending physician, or
- an owner, operator, or employee of a health care facility in which you are a patient or resident, unless you appointed him or her as your health care representative before your admission to the facility.

In addition, you may not appoint your parent or former guardian without a court order if you were ever removed from their custody and a court terminated your parent's parental rights or permanently removed you from your former guardian's home for safety reasons.

Should I add personal instructions to Part B of my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be

sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your **appointment of health care representative** goes into effect when your doctor determines that you are no longer able to make or communicate your healthcare decisions.

Your **health care instructions** go into effect when your doctor determines that you are no longer able to make or communicate your healthcare decisions, and a condition you have given instructions on arises.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your health care representative is not authorized to make health care decisions with respect to (1) mental health treatment, (2) sterilization, (3) abortion, or (4) withholding or withdrawing life-sustaining procedures unless given authority to do so by initialing the appropriate statements in sections a, b, and c of Part 3.A. of your Advance Directive.

Your agent will be bound by the current laws of Oregon as they regard pregnancy and termination of pregnancies.

What if I change my mind?

If your Advance Directive includes instructions regarding withdrawal of life support or tube feeding, you may revoke your Advance Directive at any time and in any manner that expresses your intent to revoke it.

In all other cases, you may revoke your Advance Directive at any time and in any matter as long as you are capable of making medical decisions.

Your Oregon Advance Directive will automatically be revoked if you execute a new Oregon Advance Directive, unless you have specified otherwise in your document. The directions in your Advance Directive supersede any directions contained in a previous court appointment or other advance directive; and any prior inconsistent expressions of preferences with respect to health care decisions.

If you appoint your spouse as your health care representative, the appointment is automatically revoked if you petition for divorce or annulment, unless you reaffirm your health care representative's appointment in writing.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and

grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Oregon law requires you to use state-mandated forms for your Appointment of Health Care Representative and Health Care Instructions. This packet contains the state-mandated forms with no modifications other than the addition of the instructions in the grey bar on the left side of each page. If you have health care planning needs that are not covered by these forms, you should talk to an attorney about your options.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

PART A

OREGON ADVANCE DIRECTIVE FOR HEALTH CARE

INTRODUCTION

• This Advance Directive form allows you to:

• Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.

• Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

• Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes. It is recommended that you complete this entire form.

• The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

• In sections 1, 2, 5, 6 and 7 you appoint a health care representative.

• In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself or are unable to make your own medical decisions. The person is called a health care representative. If you do not have an effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

• If you have completed an advance directive in the past, this new advance directive will replace any older directive.

• You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.

• If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.

• In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

PART 1

PRINT YOUR NAME, DATE OF BIRTH, PHONE NUMBERS, ADDRESS, AND EMAIL

1. ABOUT ME

Name: _____ Date of Birth: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

PART 2

2. MY HEALTH CARE REPRESENTATIVE

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

PRINT THE NAME, RELATIONSHIP, TELEPHONE NUMBERS, ADDRESS, AND EMAIL OF YOUR REPRESENTATIVE

Name: _____ Relationship:_____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

PRINT THE NAME, RELATIONSHIP, TELEPHONE NUMBERS, ADDRESS, AND EMAIL OF YOUR FIRST AND SECOND ALTERNATE REPRESENTATIVES

First alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

Second alternate health care representative:

Name: _____ Relationship: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell)_____

Address: _____

E-mail: _____

PART 3

ONLY INITIAL THE OPTION THAT BEST DESCRIBES YOUR PREFERENCE REGARDING LIFE SUPPORT IN THE EVENT YOU HAVE A "TERMINAL CONDITION", AS IT IS DEFINED IN THIS DOCUMENT

3. MY HEALTH CARE INSTRUCTIONS

This section is the place for you to express your wishes, values and goals for care. Your instructions provide guidance for your health care representative and health care providers.
You can provide guidance on your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

A. MY HEALTH CARE DECISIONS:
There are three situations below for you to express your wishes. They will help you think about the kinds of life support decisions your health care representative could face. For each, choose the one option that most closely fits your wishes.

a. Terminal Condition

This is what I want if:

- I have an illness that cannot be cured or reversed.

AND

- My health care providers believe it will result in my death within six months, regardless of any treatments.

Initial one option only.

___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.

__ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

b. Advanced Progressive Illness

This is what I want if:

• I have an illness that is in an advanced stage.

AND

• My health care providers believe it will not improve and will very likely get worse over time and result in death.

AND

• My health care providers believe I will never be able to:

- Communicate
- Swallow food and water safely
- Care for myself
- Recognize my family and other people

ONLY INITIAL THE OPTION THAT BEST DESCRIBES YOUR PREFERENCE REGARDING LIFE SUPPORT IN THE EVENT YOU HAVE AN "ADVANCED PROGRESSIVE ILLNESS", AS IT IS DEFINED IN THIS DOCUMENT

Initial one option only.

____I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

____I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.

____I do not want treatments to sustain my life, such as artificial feeding an hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

____I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

c. Permanently Unconscious

This is what I want if:

I am not conscious.

AND

If my health care providers believe it is very unlikely that I will ever become conscious again.

ONLY INITIAL THE OPTION THAT BEST DESCRIBES YOUR PREFERENCE REGARDING LIFE SUPPORT IN THE EVENT YOU ARE "PERMANENTLY UNCONSCIOUS", AS IT IS DEFINED IN THIS DOCUMENT

Initial one option only.

___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.

___ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

You may write in the space below or attach pages to say more about what kind of care you want or do not want.

_____

_____

_____

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

INITIAL ANY OF THE STATEMENTS THAT ARE APPLICABLE TO YOU

ATTACH ADDITIONAL PAGES, IF NEEDED

B. WHAT MATTERS MOST TO ME AND FOR ME:

This section only applies when you are in a terminal condition, have an advanced progressive illness or are permanently unconscious. If you wish to use this section, you can communicate the things that are really important to you and for you. This will help your health care representative.

This is what you should know about what is important to me about my life:

_____

This is what I value the most about my life:

_____

This is what is important for me about my life:

_____

I do not want life-sustaining procedures if I cannot be supported and be able to engage in the following ways:

Initial all that apply.

___ Express my needs.

___ Be free from long-term severe pain and suffering.

___ Know who I am and who I am with.

___ Live without being hooked up to mechanical life support.

___ Participate in activities that have meaning to me, such as:

_____

If you want to say more to help your health care representative understand what matters most to you, write it here. (For example: I do not want care if it will result in.....)

_____

_____

_____

PART 4

THIS PART IS OPTIONAL: IT ALLOWS YOU TO PROVIDE YOUR APPOINTED REPRESENTATIVES AND HEALTH CARE PROVIDERS WITH MORE INFORMATION ABOUT YOUR VALUES, PREFERRED CARE SETTINGS, OR IMPORTANT DOCUMENTS.

4. MORE INFORMATION

Use this section if you want your health care representative and health care providers to have more information about you.

A. LIFE AND VALUES

Below you can share about your life and values. This can help your health care representative and health care providers make decisions about your health care. This might include family history, experiences with health care, cultural background, career, social support system and more.
You may write in the space below or attach pages to say more about your life, beliefs and values.

_____
_____

B. PLACE OF CARE:

If there is a choice about where you receive care, what do you prefer? Are there places you want or do not want to receive care? (For example, a hospital, a nursing home, a mental health facility, an adult foster home, assisted living, your home.)
You may write in the space below or attach pages to say more about where you prefer to receive care or not receive care.

_____
_____

C. OTHER:

You may attach to this form other documents you think will be helpful to your health care representative and health care providers. What you attach will be part of your Advance Directive.
You may list documents you have attached in the space below.

_____
_____

ALSO OPTIONAL, SECTION D ALLOWS YOU TO LIST PEOPLE WITH WHOM YOU WOULD LIKE MEDICAL INFORMATION SHARED

D. INFORM OTHERS:

You can allow your health care representative to authorize your health care providers to the extent permitted by state and federal privacy laws to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name: _____

Relationship: _____

Telephone numbers: (Home) _____

(Work) _____ (Cell) _____

Address: _____

E-mail:_____

PART 5

SIGN YOUR NAME AND DATE THE DOCUMENT

PART 6

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE. IN THE ALTERNATIVE, YOU MAY HAVE THIS DOCUMENT NOTARIZED BY A NOTARY PUBLIC IN THE STATE OF OREGON

5. MY SIGNATURE

My signature: _____

Date: _____

6. WITNESS

COMPLETE EITHER A OR B WHEN YOU SIGN

A. NOTARY:

State of _____
County of _____

Signed or attested before me on _____, 2 _____, by _____.

_____
Notary Public — State of Oregon

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____

Date: _____

Witness Name (print): _____

Signature: _____

Date: _____

PART 7

YOUR REPRESENTATIVE (OR ALTERNATIVE REPRESENTATIVE(S)) MUST SIGN, DATE, AND PRINT HIS/HER/THEIR NAME(S) HERE IN ORDER FOR HIS/HER/THEIR AUTHORITY TO GO INTO EFFECT

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name:_____

Signature or other verification of acceptance:
_____

Date: _____

First alternate health care representative:

Printed name: _____

Signature or other verification of acceptance:
_____

Date: _____

Second alternate health care representative:

Printed name:_____

Signature or other verification of acceptance:
_____

Date:_____

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

OREGON ORGAN DONATION FORM — PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your health care representative or other agent, or your family, may have the authority to make a gift of all or part of your body under Oregon law.

_____I do not want to make an organ or tissue donation and I do not want my health care representative or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Oregon law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

_____

_____

_____

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

Courtesy of CaringInfo
www.caringinfo.org