 ADDRESS DOB

# ADVANCE DIRECTIVE FOR MEDICAL / SURGICAL TREATMENT (Living Will)

On completion, give copies to your physician, family members, and Healthcare Agent. If you wish to revoke or replace this document, mark it clearly as 'Revoked" or destroy it and al/ its copies, ifpossible. Ifyou do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.

# l. DECLARATION

 am

at least eighteen years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

A. Terminal Condition

If at any time my physician and one other

qualified physician certify in Writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

1. Life-Sustaining Procedures (initial one):

 (Initials) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not induding any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

 (Initials) i direct that life-sustaining procedures shall be continued for/until (state

timeframe or goal):

# 2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

 (Initials) Artificial nutrition and hydration shall not be continued.

 (Initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

 (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

# B. Persistent Vegetative State

If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

1. Life-Sustaining Procedures (initial one):

 (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

 (Initials) direct that life-sustaining procedures shall be continued for/untjl (state timeframe or goal):

1. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

 (Initials) Artificial nutrition and hydration shall not be continued.

 (Initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

 (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

# OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.) (initial one):

 (Initials) Yes, I have attached other directions.

 (Initials) No, I do not have any other directions.

# Ill. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (initial one)

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| --- |
| E-461A 10-10 uchealth.org Scan 10.' Advance Directives |

 (Initials) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or aner I appointed that Agent.  (Initials) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

# IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

Name Relationship

# VI". DECLARATION OF WITNESSES This declaration was signed by (name of Declarant)

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We declare that, at the time the Declarant signed this declaration:

* We did not sign the Declarant's signature.  We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient.

|  |
| --- |
|  this declaration was signed. |

* We are neither creditors nor heirs or Il Declarant and have no claim against any portion of the Declarant's estate at the time

V. NOTIFICATION OF OTHER PERSONS Before withholding or withdrawal life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State.

My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

Name Telephone number or email

# VI. ANATOMICAL GIFTS

 (Initials) I wish to donate my (check one or both) organs and/ortissues, if medically possible.

 (Initials) I do not wish donate my organs or tissues.

# VI'. SIGNATURE

I execute this declaration, as my free and voluntary act, this\_ day of 20

Declarant signature

## Declarant Printed Name

Pursuant to Colorado Revised Statute 15-18.101—113

 We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

Signature of Witness

## Printed Name

## Address

Signature of Witness

## Printed Name



## Address

Notary Certificate (optional)

State of

County of

SUBSCRIBED and affirmed before me by the Declarant, as the voluntary act and deed of the Declarant this day of 20 Notary Public

My commission expires