Medical Directive Form

Use this form to record your healthcare wishes, name the person you want to speak for you, and tell your care team how you want to be treated if you cannot speak for yourself. Give a signed copy to your agent, your physician, and your family.

Advance directive law is set state by state. Confirm your state's statutory form and its witnessing rules before you sign. Complete every section that applies to you. Draw a line through any section you leave blank, then add your initials beside it.

1. PATIENT IDENTIFICATION

Full legal name _____ **Date of birth** _____ mm / dd / yyyy

Home address _____

City _____ **State** _____ **ZIP** _____

Phone _____ **Email** _____

Record / MRN number _____ **State whose law applies** _____ **Date completed** _____ mm / dd / yyyy

2. HEALTHCARE AGENT DESIGNATION

I name the person below as my healthcare agent. My agent may make healthcare decisions for me from the moment my physician decides that I cannot make them myself. In most states an agent must be at least 18 years old. Your treating physician, and staff who work for your provider, usually cannot serve.

Primary agent

Full name _____ **Relationship to me** _____

Address _____ **City / State / ZIP** _____

Phone _____ **Second phone** _____ **Email** _____

Alternate agent — acts if my primary agent is unavailable, unwilling, or unable to serve

Full name _____ **Relationship to me** _____

Address _____ **City / State / ZIP** _____

Phone _____ **Second phone** _____ **Email** _____

Limits on my agent's authority (write "none" if there are no limits)

BEFORE YOU SIGN

- [ ] Talk your wishes through with the person you are naming as agent
- [ ] Check your state's witnessing and notary rules
- [ ] Complete pages 2 and 3, then sign in front of your witnesses or a notary
- [ ] Give a signed copy to your agent, your physician, and your family
- [ ] Review the form every three to five years, and after any major life change

3. TREATMENT PREFERENCES (LIVING WILL)

These choices apply when I am dying, permanently unconscious, or otherwise unable to decide for myself, and my physician judges that treatment will not return me to a condition I would accept. Check one box in each row. A time-limited trial means start the treatment, then stop it if it is not working.

TREATMENT	I WANT IT	I DO NOT WANT IT	TIME-LIMITED TRIAL
Cardiopulmonary resuscitation (CPR) Chest compressions and defibrillation to restart my heart	☐	☐	☐
Mechanical ventilation A breathing machine when I cannot breathe on my own	☐	☐	☐
Artificial nutrition Food given through a feeding tube	☐	☐	☐
Artificial hydration Fluids given through a drip or a tube	☐	☐	☐
Dialysis Machine treatment when my kidneys stop working	☐	☐	☐
Antibiotics Drugs for an infection that would otherwise end my life	☐	☐	☐
Blood transfusion Blood or blood products given to me	☐	☐	☐
Comfort care and pain relief Medication to keep me comfortable, even if it shortens my life	☐	☐	☐

Other instructions, values, or situations I want my care team to weigh

4. PRIMARY PHYSICIAN DESIGNATION

Name the clinician you want told about this directive and asked to carry it out. Leave it blank if you do not have one, or name the practice you use.

Physician name _____ **Practice or health system** _____

Address _____ **Phone** _____

Second physician or practice _____ **Phone** _____

5. ORGAN AND TISSUE DONATION

Check one box. This section is optional, and leaving it blank does not affect the rest of the form.

☐ I give any organs or tissues that are needed ☐ I do not wish to donate organs or tissues ☐ My agent or next of kin decides

☐ I give only these organs or tissues: _____

Purpose (check all that apply)

☐ Transplant ☐ Therapy ☐ Research ☐ Education

6. SIGNATURE OF THE PRINCIPAL

I sign this directive of my own free will. I understand what it says, I am at least 18 years old, and I am of sound mind. I revoke any medical directive I signed before today.

Signature _____ **Date** _____ mm / dd / yyyy

Print name _____ **City and state where signed** _____

If I cannot sign, another adult may sign for me, in my presence and at my direction.

Signature of that person _____ **Print name** _____ **Date** _____ mm / dd / yyyy

7. WITNESS STATEMENT

Witnessing rules vary by state. Most states ask for two adult witnesses, and some also accept a notary public as an alternative. Check your state's specific requirements before you sign.

> Each witness signs below. I saw the principal sign this directive, or the principal told me that the signature on it is theirs. The principal appeared to be of sound mind and under no duress. I am not the principal's healthcare agent, treating physician, or an employee of the provider treating them. I have no claim on the principal's estate.

Witness 1

Signature _____ **Print name** _____ **Date** _____ mm / dd / yyyy

Address _____

Witness 2

Signature _____ **Print name** _____ **Date** _____ mm / dd / yyyy

Address _____

8. NOTARY ACKNOWLEDGMENT

Complete this block only if your state accepts a notary in place of witnesses, or if you want the extra proof on the record.

State of _____ **County of** _____

NOTARY SEAL

On the date below, the principal named on this form appeared before me, proved their identity, and signed this directive.

Notary signature _____ **Date** _____ mm / dd / yyyy

Printed name _____ **Commission expires** _____ mm / dd / yyyy

9. FOR PRACTICE USE — DOCUMENT AUDIT TRAIL

Received by _____ **Date received** _____ mm / dd / yyyy **Chart / document reference** _____

Sections checked for completeness

☐ Identification ☐ Agent ☐ Treatment preferences ☐ Physician ☐ Signature ☐ Witness or notary

Copies given to

☐ Patient ☐ Agent ☐ Primary physician ☐ Family ☐ State registry

Filed in record by _____ **Date filed** _____ mm / dd / yyyy **Version** _____

Supersedes directive dated _____ mm / dd / yyyy **Next review date** _____ mm / dd / yyyy