Living Will Form

Declaration of [Full Name], the Declarant

I, *[Full Name]* _____, being of sound mind, voluntarily make this declaration to be followed if I become unable to participate in decisions about my medical treatment.

ARTICLE I: STATEMENT OF INTENT

I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw medical treatment in accordance with the choice I have marked below:

☐ I direct that my life be prolonged to the greatest extent possible, consistent with sound medical practice, regardless of my condition.

☐ I direct that my life not be prolonged if (1) I have an incurable, irreversible condition that will result in my death within a relatively short time; (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.

ARTICLE II: MEDICAL PREFERENCES

1. **Resuscitation Preferences:**

☐ I consent to the use of CPR.

☐ I do not consent to the use of CPR.

2. **Mechanical Ventilation Preferences:**

☐ I consent to the use of mechanical ventilation.

☐ I do not consent to the use of mechanical ventilation.

3. **Artificial Nutrition and Hydration Preferences:**

☐ I consent to the use of artificial nutrition and hydration.

☐ I do not consent to the use of artificial nutrition and hydration.

4. **Pain Management Preferences:**

☐ I consent to receiving all available pain relief methods.

☐ I have specific preferences regarding pain management, as attached in Appendix A.

5. **Organ and Tissue Donation Preferences:**

☐ I consent to organ and tissue donation as allowed by law.

☐ I do not consent to organ and tissue donation.

ARTICLE III: ALTERNATIVE PHYSICIANS

If I have named preferred or non-preferred physicians, their details are attached in Appendix B.

ARTICLE IV: SIGNATURE AND WITNESSES

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed: _____ **Date:** _____

Witness #1: Signature: _____

Name: _____ **Address:** _____

Witness #2: Signature: _____

Name: _____ **Address:** _____

[Notary Acknowledgment, if required]

ARTICLE V: REVOCATION

☐ I understand that I may revoke this Living Will at any time.

APPENDIX A: SPECIFIC PREFERENCES REGARDING PAIN MANAGEMENT

I, *[Full Name]* _____, specify the following preferences concerning pain management:

☐ I prefer non-opioid pain relievers over opioid-based pain medications whenever feasible.

☐ I would like to be consulted about the potential side effects of any pain management medications or procedures.

I am allergic to or have had adverse reactions to the following pain medications:

Other specific pain management instructions:

APPENDIX B: DETAILS OF ALTERNATIVE PHYSICIANS

If, for any reason, my primary physician is unavailable or unwilling to act under my wishes as expressed in this Living Will, I designate the following alternative physicians:

Preferred Physician:

Name: _____

Phone: _____

Address: _____

Specialty: _____

Non-Preferred Physician: If possible, I do not wish to be treated by the following physician:

Name: _____

Phone: _____

Address: _____

Specialty: _____