ADVANCE HEALTH CARE DIRECTIVE

(LIVING WILL)

WRITTEN BY:

Name _____

Address _____

City _____

Province or Territory _____ Postal Code _____

INSTRUCTIONS TO PERSONS COMPLETING THIS DIRECTIVE

- You may wish to discuss this directive with your doctor before completing it.
- Be sure the directive clearly expresses your personal wishes, i.e., if there is any section you do NOT wish to include, cross it out and initial the cross-out. There are special instructions in paragraph 5 for expressing personal wishes.
- The directive should not be signed until you are in the presence of your witness.
- Your witness is asserting that you are of sound mind and making this directive of your own free will.
- Keep this original document in a safe but accessible place known to your family, caregiver, and doctor.
    - Name of physician _____
    - Phone number _____
- Give copies of your directive to all whom it may concern.

To my family, my friends, my physicians, and all others to whom it may concern:

I, _____ voluntarily make this directive concerning my health care in the circumstances set out herein.

I believe that when there is not reasonable expectation of recovery from disease or injury, the continuation of my life by life support systems and/or medical therapy will be contrary to my right of autonomy.

It is my intention that this Directive be respected by my physician, my family, and friends, if I am no longer capable of consenting to health care on my own behalf.

DIRECTIVE

1. This directive shall apply in the event that:
   (a) I am no longer able to make or communicate decisions for my own health care.
   (b) There is no reasonable expectation of my recovery from extreme physical or mental disability, or if I am afflicted with irreversible injury, disease or illness.

2. For the purpose of determining whether the circumstances set out in Number 1 exist, I stipulate that when possible, the opinion of two medical doctors who have examined me shall be determinative.

3. When death is inevitable, I would accept the performance of any procedure or administration of medication deemed necessary to provide me with compassionate care and comfort.

4. Where the application of medical procedures would primarily serve to prolong the moment of my death or maintain my life in the circumstances set out in Part 1, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally.

5. Below, I have placed an X in the box beside all measures for extending life that are unacceptable to me when where is no reasonable expectation of my recovery and which are to be withheld or withdrawn in that case. I have initialled those measures that I would still accept even if there is no real hope of my recovery.

[ ] (a) resuscitation of my heart (defibrillation and chest compression)

[ ] (b) artificial supportive breathing except for the purpose of organ donation (mechanical ventilation on a respirator)

[ ] (c) dialysis to replace kidney function

[ ] (d) surgical procedures

[ ] (e) radiation

[ ] (f) chemotherapy

[ ] (g) medications other than those used for comfort

[ ] (h) blood transfusion

[ ] (I) diagnostic tests

[ ] (j) special feeding, whether food into the vein (parenteral) or tube feeding into the stomach (enteral).

6. When circumstances have arisen that bring this directive into effect, I request that a "Do Not Resuscitate" (DNR) notification be with me at all times, whether I am at home, in hospital, other health care facility, or in transport.

7. If I should happen to be under the care of a physician who cannot respect my wishes as expressed in this document, I direct that the physician withdraw from my care, and that I be placed under the care of another physician who will respect my views. Similarly, I direct that I be transferred to another hospital if necessary to honour the directions in this document.

8. No participant in the making or carrying out of this directive, whether it be a health care provider, hospital administrator, spouse, relative, friend or any other person, shall be held responsible in any way, legally or professionally, for any consequences arising from the implementation of my wishes.

9. This directive shall have no force and effect if revoked by me orally or in writing.

(Optional Clauses)

A. Proxy: The following person(s) is named to act as my proxy for health care. As my proxy, this person is authorized to consent to my health care when I am unable to communicate AND to consent to withdrawal of treatment on my behalf when circumstances described in paragraph 1, page 2 come into effect.

(1) _____ Phone _____

Address _____ AND/OR

(2) _____ Phone _____

Address _____ AND/OR

(3) _____ Phone _____

Address _____

B. I consent to the use after my death of any needed organs or parts of my body for transplantation.

C. If I am pregnant, and there is any prospect that the child can survive, this directive shall have no force during the course of my pregnancy.

SIGNED AND DECLARED

By the said _____

This _____ day of _____ , A.D. 20 _____

_____ _____

Witness Address

_____