Honoring My Care Decisions

Peace of Mind is Planning Ahead

Full Name: _____ Date of Birth: _____

Address _____ City: _____ State: _____ Zip code: _____

Phone#: _____ Phone#: _____ Email: _____

(Cell / Home / Work) (Cell / Home / Work)

Advance Directive/Declaration

I, _____, believe that my life deserves to be treated with dignity. I desire that my dying shall not be artificially prolonged under the circumstances set forth below.

If at any time:

1. I have an incurable injury, disease, or illness, or am in a continual, profound comatose state with no reasonable chance of recovery

AND

2. My doctor and one other doctor examine me and indicate that I have a terminal and irreversible condition and death will occur whether or not life-sustaining procedures are utilized, or life-sustaining procedures would serve only to artificially prolong the dying process, then, I direct the following instructions be followed.

Check one of the following:

____ That all life-sustaining procedures be withheld or withdrawn, **including** the provision of artificial nutrition and hydration. Focus on making me comfortable and allow natural death.

OR

____ That all life-sustaining procedures be withheld or withdrawn, **except** nutrition and hydration. If the invasive administration of nutrition and hydration is excessively burdensome as determined by my physician, Healthcare Power of Attorney, or other legal decision maker, it may be withdrawn.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my Healthcare Power of Attorney, other legal decision maker, family and/or physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Under Louisiana Law, two witnesses must verify your signature and the date. These witnesses must be 18 years of age or older and not related by blood or marriage, nor stand to gain financially in the event of your death.

This document states my wishes about my future healthcare decisions.

_____	_____	_____
Your Signature	Print Your Name	Date

I certify that I am at 18 years of age or older and not related by blood or marriage, nor stand to gain financially in the event of the death of the person completing this document.

Witness 1 Signature

_____	_____	_____
Signature	Print Name	Date

Witness 2 Signature

_____	_____	_____
Signature	Print Name	Date

***Notarization of your Advance Directive Document is optional in Louisiana. ***