

Patient Sticker



**ADVANCE DIRECTIVE
Advance Care Plan**

INSTRUCTIONS: COMPETENT ADULTS AND EMANCIPATED MINORS MAY GIVE ADVANCE INSTRUCTIONS USING THIS FORM OR ANY FORM OF THEIR OWN CHOOSING. THIS DOCUMENT MUST BE SIGNED AND EITHER WITNESSED OR NOTARIZED TO BE LEGALLY BINDING

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Quality of Life.

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (**you can check as many of these as you may want**):

- Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- End-Stage Illness:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve). I direct that medically appropriate treatment be provided as follows. **Checking “Yes” means I WANT the treatment. Checking “No” means I DO NOT want the treatment.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>CPR (Cardiopulmonary Resuscitation):</u> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Life Support / Other Artificial Support:</u> continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Treatment of New Condition:</u> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Tube feeding / IV Fluids:</u> Use of tubes to deliver food and water to patient’s stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.: _____

(Attach additional pages if necessary)

Organ Donation (Optional): If appropriate, I wish to be an organ donor: ___ Yes ___ No (please mark one)

Signature:

Your signature should either be witnessed by two competent adults **or** notarized. If witnessed, neither witness can be the person you appointed as your agent, and at least one of the witnesses cannot be someone who is related to you or entitled to any part of your estate.

Signature: _____
(Patient)

Date: _____

Witnesses:

1. I am a competent adult who is not the named Agent above. I witnessed the patient's signature.

Witness Signature -1

2. I am a competent adult who is not the named Agent above. I am not related to the patient by blood, marriage, or adoption and upon patient's death, I would not be entitled to any portion of the patient's estate under any existing will, codicil or by operation of law. I witnessed the patient's signature.

Witness Signature -2

OR this document may be notarized instead of witnessed

Notary:

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My Commission Expires: _____

Notary Public