

Patient Sticker

ADVANCE DIRECTIVE Advance Care Plan

PLEASE NOTE: 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.



CSN001

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): Upon my death, I wish to make the following anatomical gift (please mark one):

Any organ tissue My entire body Only the following organs/tissues: _____



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 not related to you or entitled to any part of your estate.

Signature: _____ Date: _____
(Patient)

Witnesses:

We, the undersigned, do hereby certify that the above named Declarant signed this Advance Directive in our presence, and we, at the Declarant's request, in the Declarant's presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that the Declarant's signature was voluntary.

Signature

Witness

Printed Name

Printed Name

Address

Address

Address

Address

OR

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

