OKLAHOMA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
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CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

This packet contains a legal document, the **Oklahoma Advance Directive for Health Care**, that protects your right to refuse medical treatment you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, Part III, or any or all of these parts, depending on your advance planning needs. You must complete Part V.

Part I of the Advance Directive is the **Living Will**. It lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are terminally ill, persistently unconscious, or have an end-stage condition.

Part I goes into effect when your doctor determines that you are no longer able to make your own decisions, and that you are terminally ill, persistently unconscious, or have an end-stage condition.

Part II is the **Appointment of Health Care Proxy.** This section lets you name someone to make decisions about your health care if you can no longer speak for yourself. Appointing a health care proxy can be especially useful, because your health care proxy's authority is active whenever you cannot make decisions for yourself, not just at the end of life.

Part III addresses **Anatomical Gifts**. This Part allows you to indicate whether you want to donate any or all of your organs and tissues after your death.

Part IV contains general provisions regarding your advance directive for health care.

Part V contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: This document will be legally binding only if the person completing it is 18 years of age or older.

INSTRUCTIONS FOR COMPLETING YOUR OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

How do I make my Advance Directive legal?

The law requires that you sign your Oklahoma Advance Directive for Health Care in the presence of two witnesses who are at least eighteen years of age. Your witnesses cannot be related to you or be any person who can inherit from your estate.

Who should I pick as my health care proxy?

Your health care proxy is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate health care proxy. The alternate will step in if the first person you name as your health care proxy is unable, unwilling, or unavailable to act for you.

Should I add instructions to my advance directive for health care?

One of the strongest reasons for naming a health care proxy is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your health care proxy carry out your wishes, but be careful that you do not unintentionally restrict your health care proxy's power to act in your best interest. In any event, be sure to talk with your health care proxy about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Oklahoma Advance Directive for Health Care at any time and in any manner, regardless of your mental or physical condition. Your revocation is effective once you, or a witness to your revocation, notify your doctor or other health care provider.

What other important facts should I know?

Your Oklahoma Advance Directive for Health Care will not be honored if you are pregnant unless you have specifically authorized that life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn during pregnancy.

OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE
PAGE 1 OF 8

PRINT YOUR NAME

If I, _____ (name), am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

PART I

Part I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below.

1. If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

INITIAL ONLY ONE

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

2. If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

INITIAL ONLY ONE

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

3. If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

INITIAL ONLY ONE

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

4. Other. Here you may:
   (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn;

   (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition; or

   (c) do both of these.

(Attach additional pages, if needed.)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

ALTHOUGH A LIVING WILL IS ONLY OPERATIVE TO DETERMINE YOUR HEALTH CARE WISHES, YOU MAY WISH TO MEMORIALIZE OTHER INSTRUCTIONS AS WELL, ALTHOUGH THEY MAY NOT BE LEGALLY BINDING

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES, IF NEEDED

PART II

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR HEALTH CARE PROXY AND ALTERNATE HEALTH CARE PROXY

Part II. Appointment of my Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of

Name of health care proxy:_____,
Address:_____
_____,
Telephone number:_____,

whom I appoint as my health care proxy. If my health care proxy is unable, unwilling, or not reasonably available to serve, I appoint

Name of alternate health care proxy:_____,
Address:_____
_____,
Telephone number:_____,

as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able. However, my health care proxy or alternate health care proxy must make decisions consistent with any choices I have made in this document regarding life-sustaining treatment and artificially administered nutrition and hydration.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

When making health-care decisions for me, my health care proxy should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care proxy should make decisions for me that my health care proxy believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

ADD OTHER INSTRUCTIONS FOR YOUR HEALTH CARE PROXY, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES, IF NEEDED

I further direct that:

(Attach additional pages, if needed.)

PART III

OPTIONAL

INITIAL ALL USES TO WHICH YOU AGREE FOR YOUR GIFT

INITIAL ONLY ONE

Part III. Anatomical Gifts (Organ Donation)

Initial the line next to the choices below that best reflect your wishes. You do not have to initial any of the choices. If you do not initial any of the choices, your proxy, guardian, or other agent, or your family, may have the authority to make a gift of all or part of your body under Oklahoma law.

Pursuant to the provisions of the Oklahoma Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

_____ Transplantation

_____ Therapy

_____ Advancement of medical science, research, or education

_____ Advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:

_____ My entire body, or

_____ The following organs or body parts:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PART IV

Part IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.

b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.

c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

GENERAL PROVISIONS

d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of any life-sustaining procedures, and I accept the consequences of such choice or refusal.

e. This advance directive shall be in effect until it is revoked.

f. I understand that I may revoke this advance directive at any time.

g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

PART V

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR CITY, COUNTY, AND STATE OF RESIDENCE AND DATE OF BIRTH

YOUR WITNESSES SIGN AND DATE HERE AND PRINT THEIR ADDRESSES

Part V. Execution

Signed this _____day of _____, 20 _____.

_____
(signature)

_____
(printed name)

_____
(city, county and state of residence)

_____
Date of birth

Witnesses: This advance directive was signed in my presence.

Witness # 1

_____
(signature of witness) (date)

_____
(printed name)

_____
(address)

_____
(city, state and zip code)

Witness # 2

_____
(signature of witness) (date)

_____
(printed name)

_____
(address)

_____
(city, state and zip code)

Courtesy of CaringInfo
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www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Oklahoma Advance Directive for Health Care is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your proxy and alternate proxy, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your proxy(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Oklahoma document.

7. Be aware that your Oklahoma document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

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OR donate online today: www.NationalHospiceFoundation.org/donate