The following is the Advance Directive for Healthcare statutory form:

Declaration

I, _____, being of sound mind, willingly and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I ☐ do ☐ do not want cardiac resuscitation.

I ☐ do ☐ do not want mechanical respiration.

I ☐ do ☐ do not want tube feeding or any other artificial or invasive form of nutrition (food).

I ☐ do ☐ do not want tube feeding or any other artificial or invasive form of hydration (water).

I ☐ do ☐ do not want blood or blood products.

I ☐ do ☐ do not want any form of surgery or invasive diagnostic tests.

I ☐ do ☐ do not want kidney dialysis.

I ☐ do ☐ do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other Instructions

I ☐ do ☐ do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable)

_____

_____

_____

Name and address of substitute surrogate (if surrogate designated above is unable to serve)

_____

_____

_____

continued on reverse side

Statutory Form of Declaration

Thomas Jefferson University Hospitals
Jefferson Health System
Thomas Jefferson University Hospital — Center City
Ford Road
Methodist Hospital Division
Jefferson Hospital for Neuroscience

continued from inside

I ☐ do ☐ do not want to make an anatomical gift of all or part of my body, subject to the following limitations (if any).

I made this declaration on the _____ day of _____ month, 20_____

Declarant: _____

Signature: _____

Address: _____

The declarant, or the person on behalf of and at the direction of the declarant, knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness: _____

Signature: _____

Address: _____

Witness: _____

Signature: _____

Address: _____

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