

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, as determined by a qualified physician.

Agent: I want the following person to make health care decisions for me:

Name: _____
Phone: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____
Phone: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable (clean, comfortable and pain-free) quality of life. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of those items as you want):

- Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma, as determined by my physician.
- 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 Illnesses: 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.

- Yes No CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
- Yes No Life Support/Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs continue to work.

Yes No Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

Yes No Tube feeding/IV fluids: 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):

- I do not wish to donate any organs/tissues
- Any organ/tissue My entire body Only the following organs/tissues: _____

This document states my wishes and choices as of _____ (date).

Signature:

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

Signature of Patient

Date: _____

Witnesses:

- 1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Signature of Witness 1

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

Signature of Witness 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE/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 who signed 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: _____

Signature of Notary Public