

# ADVANCE HEALTH CARE DIRECTIVE

I, \_\_\_\_\_ (I.C. NO: \_\_\_\_\_),  
being of sound mind, declare that:

## END-OF-LIFE DECISIONS

1. I direct that my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choices I have marked below:

(a) **Choice NOT to Prolong Life.**

I do not want my life to be prolonged if:

1. I have an incurable and irreversible condition that will result in my death within a relatively short time,
2. I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or
3. the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) **Choice to Prolong Life**

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.  **RELIEF FROM PAIN:** I direct that treatment for alleviation of pain or discomfort should be provided at all times **even if it hastens my death.**

3.  **CONSULTANT PHYSICIAN:**

I wish to engage the following physician **to independently advise** my family or next of kin to help me carry out my wishes:

\_\_\_\_\_  
(Name of physician)

OPTIONAL: If the physician I have requested above is not willing, able, or available to act as my consultant to advise my family or next of kin, I request to engage the following as my alternative physician:

\_\_\_\_\_  
(Name of physician)

**DONATION OF ORGANS AT DEATH**

Upon my death:

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs, tissues, or parts only:

\_\_\_\_\_

My gift is for the following purposes:

(1) Transplant

(2) Therapy

(3) Research

(4) Education

(5) Others (specify) .....

In the absence of my own ability to give directions regarding the use of life-sustaining procedures, it is my intention that this declaration shall be

