This is an important legal document. Read it carefully and talk about it with your doctor and family. It directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and are terminally ill, in a permanently unconscious condition, or in a minimally conscious condition in which you are permanently unable to make decisions or express your wishes.

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

Health Care:
If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes, it is my wish that the following directions be followed by my health care provider.

While I understand that I am not legally required to be specific about future treatments **if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:**

Directions: For each choice below: 1) Cross out any of these that you do want AND 2) write your initials next to any statement with which you agree:

_____ I do not want Cardiopulmonary Resuscitation (CPR), and I want my health care provider to issue a Do Not Resuscitate (DNR) order (an order written in my medical records that CPR is not to be administered to me).

_____ I do not want mechanical respiration.

_____ I do not want artificial nutrition and/or hydration (provision of foods and fluids through tubes).

_____ I do not want antibiotics.

_____ I do not want dialysis-cleaning the blood by machine

_____ I do not want blood transfusions/blood products

_____ I do not want invasive diagnostic tests - flexible tube to look into the stomach

_____ I do not want anti-psychotic medication

_____ I do not want electric shock therapy

_____ I do not want transplantation

_____ I do not want abortion / sterilization

_____ I do not want a pacemaker (non-cardiac related terminal or irreversible condition)

_____ I do not want surgery (you can define what surgery you do not want.)

_____ I do not want any other painful or invasive treatment that will result in prolonging my life.

_____ I DO want maximum pain relief, even if it may hasten my demise.

Other Instructions or Comments about My Care:

_____

_____

_____

_____

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed _____ Date _____

Address_____

Witnesses: Two witnesses must be 18 years of age or older and cannot be the health care agent or alternate.

I declare that the person who signed this document appeared to execute the Living Will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1:

Print Name: _____

Signature: _____

Address: _____

Tel. No.: _____

Witness 2:

Print Name: _____

Signature: _____

Address: _____

Tel. No.: _____

Optional: Organ and/or Tissue Donation

You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.

I hereby make an anatomical gift, to be effective upon my death, of (*write your initials next to the statement of your choice*):

_____ Any organs and/or tissues

_____ The following organs and/or tissues:

_____

_____

Limitations:

_____

_____

If you do not state your wishes or instructions regarding organ and/or tissue donation on this form, it will not mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Signed _____ Date: _____

Address: _____