

**OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE**  
**PAGE 1 OF 8**

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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. 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:

\_\_\_\_\_ 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:

\_\_\_\_\_ 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.

INITIAL ONLY ONE

INITIAL ONLY ONE

**OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE**  
**PAGE 2 OF 8**

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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:

\_\_\_\_\_ 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.

INITIAL ONLY ONE



**OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE**  
**PAGE 4 OF 8**

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**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, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I indicate in the following sections.

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.

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



**Part III. Anatomical Gifts (Organ Donation)**

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:

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INITIAL ALL USES  
TO WHICH YOU  
AGREE FOR YOUR  
GIFT

INITIAL ONLY ONE

**OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE**  
**PAGE 7 OF 8**

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**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.
- 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.

GENERAL  
PROVISIONS

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Palliative Care  
Organization  
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**OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE  
PAGE 8 OF 8**

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**Part V. Execution**

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
*(signature)*

\_\_\_\_\_  
*(city, county and state of residence)*

\_\_\_\_\_  
*Date of birth*

Witnesses.

This advance directive was signed in my presence.

Witness # 1

\_\_\_\_\_  
*(signature of witness)* *(date)*

\_\_\_\_\_  
*(address)*

\_\_\_\_\_  
*(city, state and zip code)*

Witness # 2

\_\_\_\_\_  
*(signature of witness)* *(date)*

\_\_\_\_\_  
*(address)*

\_\_\_\_\_  
*(city, state and zip code)*

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

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Hospice and  
Palliative Care  
Organization  
2010 Revised.

*Courtesy of Caring Connections  
1731 King St., Suite 100, Alexandria, VA 22314  
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 Google Health, or another online medical records management 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. You can read more about Google Health at <http://www.caringinfo.org/googlehealth>.
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. **Caring Connections does not distribute these forms.**