OKLAHOMA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

The goal of Caring Connections is for consumers to hear a unified message promoting awareness and action for improved end-of-life care. Through these efforts, NHPCO seeks to support those working across the country to improve end-of-life care and conditions for all Americans.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are always up to date.

CARING CONNECTIONS

HelpLine

You can call our toll-free HelpLine, 800/658-8898, if you have any difficulty understanding your state-specific advance directive, or if you are dealing with a difficult end-of-life situation and need immediate information. We can help provide resources and information on questions like these:

- How do I communicate my end-of-life wishes to my family?
- What type of end-of-life care is available to me?
- What questions should I ask my mother's doctors about her end-of-life care?

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or to join the effort to improve community, state and national end-of-life care.

HOW TO USE THESE MATERIALS

1. Check to be sure that you have the materials for your state. You should complete a form for the state in which you expect to receive health care.

2. These materials include:
   - Instructions for preparing your advance directive.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

3. Read the instructions in their entirety. They give you specific information about the requirements in your state.

4. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

5. When you begin to complete the form, refer to the gray instruction bars - they indicate where you need to mark, insert your personal instructions, or sign the form.

6. Talk with your family, friends, and physicians about your decision to complete an advance directive. Be sure the person you appoint to make decision on your behalf understands your wishes.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, you may call our toll free number 800/ 658-8898 and a staff member will be glad to assist you.

For more information contact:

The National Hospice and Palliative Care Organization
1700 Diagonal Road, Suite 625
Alexandria, VA 22314

Call our HelpLine: 800/658-8898
Visit our Web site: www.caringinfo.org

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INTRODUCTION TO YOUR OKLAHOMA ADVANCE DIRECTIVE

This packet contains a legal document, the **Oklahoma Advance Directive for Health Care**, that protects your right to refuse medical treatment you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Section I of the Advance Directive is the **Living Will**. It lets you state your wishes about medical care in the event that you can no longer make your own medical decisions and you are terminally ill or persistently unconscious.

2. Section II is the **Appointment of Health Care Proxy.** This section lets you name someone to make decisions about your medical care if you can no longer speak for yourself. Decisions regarding life-sustaining treatment can be made by your health care proxy when you can no longer speak for yourself and your doctor and one other doctor have determined that you are persistently unconscious or terminally ill.

Your Oklahoma Advance Directive for Health Care goes into effect once it is given to your doctor and you are unable to make your own medical decisions. In order to follow your instructions regarding life-sustaining treatment, your doctor must first consult another doctor to determine that you are persistently unconscious or suffering from a terminal condition. Under Oklahoma law, a terminal condition is an incurable and irreversible condition that, even with the administration of life-sustaining treatment, will result in death within six months.

Caring Connections recommends that you complete section I and section II of this document to best ensure that you receive the medical care you want when you can no longer speak for yourself.

Note: This document will be legally binding only if the person completing it is 18 years of age or older.

INTRODUCTION TO YOUR OKLAHOMA ADVANCE DIRECTIVE (CONTINUED)

How do I make my Advance Directive legal?

The law requires that you sign your Oklahoma Advance Directive for Health Care in the presence of two witnesses who are at least eighteen years of age. Your witnesses cannot be any person who would inherit from you under any existing will or by operation of law.

Note: You do not need to notarize your Oklahoma Advance Directive.

What if I change my mind?

You may cancel your Oklahoma Advance Directive for Health Care at any time and in any manner, regardless of your mental or physical condition. Your revocation goes into effect once you, or a witness to your revocation, notify your doctor or other health care provider, who must then make it part of your medical record.

What other important facts should I know?

Many of the paragraphs in your Oklahoma Advance Directive for Health Care have a place for your signature. Sign your name after each paragraph with which you agree (if the paragraph does not reflect your wishes leave the signature line blank.)
Remember to sign your name to any section in which you added personal instructions.

Section III of your Oklahoma Advance Directive allows you to state your wishes regarding organ donation.

Due to restrictions in the state law, your Oklahoma Advance Directive will not be honored if you are pregnant. If your attending physician does not know if you are pregnant, he or she shall, where appropriate, determine if you are pregnant.

COMPLETING SECTION I: LIVING WILL

Can I add personal instructions to my Living Will section?

Yes. You can add personal instructions in section 3 of parts “b” and “c.” For example, you may want to refuse specific treatments by a statement such as, “I especially do not want cardiopulmonary resuscitation, a respirator, or antibiotics.” You may also want to emphasize pain control by adding instructions such as, “I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death.”

You may also want to add personal instructions in part “d,” “Other directions.” *This is important because Oklahoma law contains a very restrictive definition of when you would be considered “terminal.”* Caring Connections recommends that you add the statement, “I do not want life support if it is likely that my death would occur without its use and there is no reasonable expectation that I will regain the ability to make decisions and express my wishes.”

If you have appointed a health care proxy under Section II and you want to give your proxy the broadest decision making authority available, Caring Connections recommends that you also add the following statement to part “d” “Any questions about how to interpret or when to apply these instructions are to be decided by my health care proxy.”

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, “Advance Directives and End-of-Life Decisions.”

What other important facts should I know?

If you do not want to receive artificial nutrition and hydration if you are terminally ill or persistently unconscious, you must sign the statement under section 2 of part “b” and “c.” If you do not sign these statements, your attending physician will not be able to withdraw or withhold artificial nutrition and hydration from you.

COMPLETING SECTION II: APPOINTMENT OF HEALTH CARE

Whom should I appoint as my health care proxy?

An attorney-in-fact is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself.

Your health care proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy must be at least 18 years of age, and should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A proxy may also be called an attorney-in-fact" or "agent.")

You can appoint a second person as your alternate proxy. The alternate will step in if the first person you name as your agent is unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Appointment of Health Care Agent?

Caring Connections advises you not to add instructions to this part of your Oklahoma Advance Directive. One of the strongest reasons for naming a proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. Your proxy is under a duty to make decisions based on your known intentions, personal views and best interests. If you add instructions here, you might unintentionally restrict your proxy's power to act in your best interest. Instead, we urge you to talk with your proxy about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use Section I of your Oklahoma Advance Directive.

What other important facts should I know?

If you want your proxy to be able to make the decision to withhold or withdraw artificial nutrition and hydration if you are terminally ill or persistently unconscious, you must sign the statements under section 2 of parts "b" and "c." If you do not sign these statements, your proxy will not have the authority to make decisions regarding the withholding or withdrawal of artificial nutrition and hydration.

AFTER YOU HAVE COMPLETED YOUR DOCUMENT

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 health care proxy and alternate proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. 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 health care proxy and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes often, particularly if your medical condition changes.

4. If you want to make changes to your document after it has been signed and witnessed, you must complete a new document.

5. Remember, you can always revoke your Oklahoma Advance Directive for Health Care if you change your mind.

6. Be aware that your Oklahoma document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. Caring Connections does not distribute these forms. We suggest you speak to your physician.

If you would like more information about this topic contact Caring Connections or consult the Caring Connections "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

INSTRUCTIONS

PRINT YOUR NAME

I, ____,
(name)

being of sound mind and eighteen (18) years of age or older, willfully and voluntarily make known my desire, by my instructions to others through my living will, or by my appointment of a health care proxy, or both, that my life shall not be artificially prolonged under the circumstances set forth below. I thus do hereby declare:

LIVING WILL

I. LIVING WILL

a. 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 Rights for the Terminally Ill or Persistently Unconscious Act, to withhold or withdraw treatment from me under the circumstances I have indicated below by my signature. I understand that I will be given treatment that is necessary for my comfort or to alleviate my pain.

TERMINAL CONDITION

SIGN ALL STATEMENTS THAT REFLECT YOUR WISHES

b. If I have a terminal condition:

(1) I direct that life-sustaining treatment shall be withheld or withdrawn if such treatment would only prolong my process of dying, and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

____
(signature or initials)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) that will only prolong the process of dying from an incurable and irreversible condition is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

____
(signature or initials)

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INSTRUCTIONS

OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

ADD PERSONAL INSTRUCTIONS (IF ANY)

(3) I direct that (add other medical directives, if any)

____

(signature or initials)

PERSISTENTLY UNCONSCIOUS

SIGN ALL STATEMENTS THAT REFLECT YOUR WISHES

c. If I am persistently unconscious:

(1) I direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

____

(signature or initials)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) for individuals who have become persistently unconscious is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

____

(signature or initials)

(3) I direct that (add other medical directives, if any)

____

(signature or initials)

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ADD PERSONAL INSTRUCTIONS (IF ANY)

d. Other directions:

____

(signature or initials)

HEALTH CARE PROXY

II. MY APPOINTMENT OF MY HEALTH CARE PROXY

PRINT THE NAME OF YOUR HEALTH CARE PROXY AND ALTERNATE

a. 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 Rights of the Terminally Ill or Persistently Unconscious Act to follow the instructions of

____, whom I
(name of health care proxy)
appoint as my health care proxy. If my health care proxy is unable or unwilling to

serve, I appoint ____ as my
(name of alternate health care proxy)
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 can be made by my health care proxy or alternate health care proxy only as I indicate in the following sections.

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SIGN ALL STATEMENTS THAT REFLECT YOUR WISHES

b. If I have a terminal condition:

(1) I authorize my health care proxy to direct that life-sustaining treatment be withheld or withdrawn if such treatment would only prolong my process of dying and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

____
(signature or initials)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition (food) or hydration (water) will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding of artificially administered nutrition and hydration.

____
(signature or initials)

ADD PERSONAL INSTRUCTIONS (IF ANY)

(3) I authorize my health care proxy to (add other medical directives, if any):

PERSISTENTLY UNCONSCIOUS

SIGN ALL STATEMENTS THAT REFLECT YOUR WISHES

c. If I am persistently unconscious:

(1) I authorize my health care proxy to direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

____
(signature or initials)

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ADD PERSONAL INSTRUCTIONS (IF ANY)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition (food) and hydration (water) will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding and withdrawal of artificially administered nutrition and hydration.

____
(signature or initials)

(3) I authorize my health care proxy to (add other medical directives, if any):

____
(signature or initials)

ANATOMICAL GIFTS

CHECK THE BOX(ES) THAT BEST REFLECTS YOUR WISHES REGARDING ORGAN DONATION AND SIGN YOUR NAME

III. ANATOMICAL GIFTS

I direct that at the time of my death my entire body or designated body organs or body parts be donated for the purpose of transplantation, therapy, advancement of medical or dental science or research or education pursuant to the provisions of the Uniform Anatomical Gift Act. 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

☐ lungs, ☐ liver, ☐ pancreas
☐ heart, ☐ kidneys, ☐ brain,
☐ skin, ☐bones/marrow,
☐ bloods/fluids, ☐tissues,
☐ arteries, ☐eyes/cornea,lens,
☐ glands, other__________________________

____
(signature or initials)

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CONFLICTING PROVISION

IF YOU WANT YOUR PROXY'S DECISIONS TO TAKE PRECEDENCE, INDICATE HERE AND SIGN YOUR NAME

IV. CONFLICTING PROVISION

I understand that if I have completed both a living will and have appointed a health care proxy, and if there is a conflict between my health care proxy's decision and my living will, my living will shall take precedence unless I indicate otherwise:

____

____

(signature or initials)

OTHER PROVISIONS

V. OTHER PROVISIONS

a. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this advance directive shall have no force or effect during the course of my pregnancy.

b. 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 refuse medical or surgical treatment including, but not limited to, the administration of any life-sustaining procedures, and I accept the consequences of such refusal.

c. This advance directive shall be in effect until it is revoked.

d. I understand that I may revoke this advance directive at any time.

e. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

f. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

YOU AND YOUR WITNESSES MUST SIGN THE DOCUMENT ON THE NEXT PAGE

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SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR CITY, COUNTY AND STATE OF RESIDENCE

Signed this _________ day of ____________________________, 20 _________.

____
(signature)

____
(city, county and state of residence)

WITNESSING PROCEDURE

This advance directive was signed in my presence.

YOUR WITNESSES SIGN HERE AND PRINT THEIR ADDRESSES

____
(signature of witness)

____
(address)

____
(signature of witness)

____
(address)

Courtesy of Caring Connections
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