

**HEALTH CARE INSTRUCTIONS IN THE EVENT OF END-STAGE
MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS
(PENNSYLVANIA LIVING WILL)**

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

END-STAGE MEDICAL CONDITION

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as an irreversible coma or an irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply:

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.
2. I direct that all life prolonging procedures be withheld or withdrawn.
3. I specifically do not want any of the following as life prolonging procedures (note: oxygen is permitted because it relieves suffering): (If you wish to receive any of these treatments, write "I do want" after the treatment)

Heart-lung resuscitation (CPR) _____
Mechanical ventilator (breathing machine) _____
Dialysis (kidney machine) _____
Surgery _____
Chemotherapy _____
Radiation treatment _____
Antibiotics _____

_____ I agree

OR

_____ I disagree

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

TUBE FEEDINGS

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have

an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

_____ I do not want tube feedings to be given.

OR

_____ I do want tube feedings to be given.

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that any intervening (other and separate) life-threatening conditions be treated in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated above.

_____ I agree.

OR

_____ I disagree.

APPOINTMENT OF SURROGATE

I do want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in an end-stage medical condition or in a state of permanent unconsciousness all as verified by my attending physician. My surrogate shall be:

Surrogate Name

Surrogate Address

Surrogate Phone Number

Surrogate Relationship

USE OF INSTRUCTIONS

_____ My Surrogate must follow these instructions.

OR

_____ These instructions are only guidance. My surrogate shall have final say and may override any of my instructions. (Indicate any exceptions):

If I did not appoint a Surrogate, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my Surrogate and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my direction. On behalf of myself, my executors and heirs, I thither hold thy Surrogate and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my Surrogate's authority or in following my treatment instructions.

ORGAN DONATION

_____ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education: (Insert here any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

_____ I do not consent to donate my organs or tissues at my death.

HAVING CAREFULLY READ THIS DOCUMENT,

I have signed it this document on the _____th day of _____month of _____ year revoking all previously executed Living Wills.

Patient Name / Date

Witness Name / Date

Patient Address

Witness Address