Medical Directives LLC

5307 Allum Rd., Unit B
Houston TX 77045
MedicalDirectives.net
T/F: 866 -300-7388

Thank you for downloading the PDF-fillable form for your Medical Directive, Advance Medical Directive, or Medical Power of Attorney. The process is very straightforward:

1. Choose the subscription type you want and pay online. We use paypal for all credit card processing and NEVER store your Credit Card Information.
2. Download the form to your computer.
3. Fill it out on your computer and print it.
4. Take the filled-form to your favorite notary (or your witnesses) and have it notarized or witnessed.
5. Fax your paperwork to 866-300-7388. If you want to email it instead, please SCAN all to PDF utilizing 200 DPI scan settings, making 1 PDF file, and email to forms@medicaldirectives.net
6. Your Retrieval Card is emailed out to you within 24 hours of receiving your medical directive. If you lose it or need another one, you can generate one easily on our web portal .

Here is the form for the state you selected. Please do not fax back any instruction sheets. We do not require a coversheet when you fax.

Advance Directive for Health Care

This form (in English, Vietnamese and Spanish) and answers to frequently asked questions (FAQS) are available at this web address: http://okpalliative.nursing.ouhsc.edu/oklaw.htm

OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

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:
(Initial only one option)

_____ 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 if applicable)

See my more specific instructions in paragraph (4) below.

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:
(Initial only one option)

_____ 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 if applicable)

_____ See my more specific instructions in paragraph (4) below.

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:

(Initial one option only)

_____ 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 if applicable)

See my more specific instructions in paragraph (4) below

4. Other.

(Here you may: [a] describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn; [b] give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition; or [c] do both of these.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

II. My 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:

_____, whom I appoint as my health care proxy.

If my health care proxy is or becomes unable or unwilling to serve, I appoint:

_____ as my alternate health care proxy with the same authority.

My healthcare proxy is authorized to make whatever health care 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 have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the 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:

(Initial all that apply)

_____ 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:

(Initial all that apply)

_____ My entire body; or

The following body organs or parts;

_____ lungs	_____ liver	_____ arteries
_____ pancreas	_____ heart	_____ glands
_____ kidneys	_____ brain	_____ tissue
_____ skin	_____ bones/marrow	_____ eyes/cornea/lens
_____ bloods/fluids	_____ tissue	_____ other

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 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.
Signed this _____ day of _____ , 2 _____ .

_____
Signature

_____ _____
Residence (City, county, and state) | Date of birth (Optional for identification purposes)

This advance directive was signed in my presence.

_____ _____
Signature of Witness | Signature of Witness

_____ _____
Address | Address

_____ _____
City/State | City/State

For assistance in filling out this form call (405) 522-3069.

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DURABLE POWER OF ATTORNEY
(WITH HEALTH CARE POWERS ONLY)

NOTICE: **The powers granted by this document are broad and sweeping. They are explained in the Uniform Statutory Form Power of Attorney Act. If you have any questions about these powers, obtain competent legal advice. Free legal information regarding construction of the powers granted by this document and completion of this form may be obtained by calling the Legal Services Developer, Aging Services Division of the Oklahoma Department of Human Services, (405) 522-3069, or your local legal aid or legal services office. This document authorizes your agent to make medical and other health-care decisions for you. You may revoke this power of attorney if you later wish to do so.**

I _____
(insert name and address)

appoint _____
(insert name and address of the person appointed)
as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects. If my agent is unable or unwilling to serve, I appoint _____
_____
(insert name and address)
as my alternate agent with the same authority.

Once effective pursuant to section III on the back of this form, this power of attorney will continue to be effective even though I become disabled, incapacitated, or incompetent, and shall not be affected by lapse of time.

I. Grant of Health Care Powers

To grant all of the following powers, initial the line in front of (f) and ignore the lines in front of the other powers.

To grant one or more, but fewer than all, of the following powers, initial the line in front of each power you are granting.

To withhold a power, do not initial the line in front of it. You may, but need not, cross out each power with held.

1. If I am unable to decide or speak for myself, my agent has the power to:

Initial

_____ a. Make health and medical care decisions for me, including serving as my representative under the Oklahoma Do-Not-Resuscitate Act, but excluding signing an advance directive, making decisions reserved to a health care proxy under an advance directive, or other life-sustaining treatment decisions.

_____ b. Choose my health care providers.

_____ c. Choose where I live and receive care and support when these choices relate to my health care needs.

_____ d. Review my medical records and have the same rights that I would have to give my medical records to other people.

_____ e. Elect hospice treatment.

_____ f. All of the powers listed above.

You need not initial any other lines if you initial line f.

2. It is my intention that my agent's acts on my behalf are to be honored by my family members and health care providers as an expression of my legal right to manage my health care. The directions and decisions of my agent are superior to and shall take precedence over any decision made by any member of my family. To the extent appropriate, my agent may discuss health care decisions with my family and others to the extent they are available.

II. Additional Guidance and Information

NOTE: **This section, while very helpful to your agent, is optional and choices may be left blank.**

a. My goals for my health care: _____
_____

b. My fears about my health care: _____
_____
_____

c. My spiritual or religious beliefs and traditions: _____
_____
_____

d. My thoughts about how my medical condition might affect my family: _____
_____
_____

e. My thoughts about living and receiving health care at home versus in a nursing home or other institution: _____
_____

Special Instructions: On the following lines you may give special instructions limiting or extending the powers granted to your agent. _____
_____
_____
_____
_____

(Attach additional pages if needed.)

III. When Power Becomes Effective

Please initial one statement below regarding the effective date of this power of attorney.
Initial

_____ This power of attorney is effective immediately and shall continue until it is revoked.

_____ This power of attorney shall be effective when my attending physician determines that I am no longer able to manage my person. This determination shall be provided in writing and attached to this form.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed: _____
(Principal's signature)

City, County, and State of Residence
_____

The principal is personally known to me and I believe the principal to be of sound mind. I am eighteen (18) years of age or older. I am not related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage. The principal has declared to me that this instrument is his power of attorney granting to the named attorney-in-fact the power and authority specified herein, and that he has willingly made and executed it as his free and voluntary act for the purposes herein expressed.

Witness: _____

Witness: _____

STATE OF OKLAHOMA)
) SS.
COUNTY OF _____)

Before me, the undersigned authority, on this _____ day of _____, 20 ____, personally appeared _____ (principal), _____ (witness), and _____ (witness), whose names are subscribed to the foregoing instrument in their respective capacities, and all of said persons being by me duly sworn, the principal declared to me and to the said witnesses in my presence that the instrument is his or her power of attorney, and that the principal has willingly and voluntarily made and executed it as the free act and deed of the principal for the purposes therein expressed, and the witnesses declared to me that they were each eighteen (18) years of age or over, and that neither of them is related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage.

_____
Notary Public

My Commission Expires: _____

By accepting or acting under the appointment, the agent assumes the fiduciary and other legal responsibilities of an agent.

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