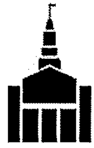 *Abington* Memorial Hospital

LIVING WILL

I, ____________________________, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

A. LIFE-SUSTAINING TREATMENT. I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in an end-stage medical condition. I also direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a state of permanent unconsciousness. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment. 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 my Healthcare Agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

(Please initial) I agree _______I disagree_____________

B. NUTRITION AND HYDRATION. If I have a condition stated above, it is my preference NOT TO RECEIVE or TO RECEIVE (circle one) tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

C. OTHER REQUESTS. In addition, if I am in a condition or state described above, I feel especially strong about the following forms of treatment:
I do ____ do not ____ want cardiac resuscitation.
I do ____ do not ____ want mechanical respiration.
I do ____ do not ____ want blood or blood products.
I do ____ do not ____ want any form of surgery or invasive procedures.
I do ____ do not ____ want kidney dialysis.
I do ____ do not ____ want antibiotics.
I do ____ do not ____ want chemotherapy.
I do ____ do not ____ want radiation treatment.
I do ____ do not ____ want to make anatomical gift of all or part of my body subject to the following limitations, if any:____.

D. HEALTHCARE AGENT DESIGNATION. I do want to designate another person as my Healthcare Agent to make medical treatment decisions for me if I should be incompetent and in an end-stage medical condition or state of permanent unconsciousness. I hereby designate ________________ currently residing at ______________________________ as my Healthcare Agent. If the person designated as my Healthcare Agent is not able to act, I designate ___________________________ currently residing at ______________________________.

I have read and understand the contents of this document and the effect of this grant of powers to my Healthcare Agent. I am emotionally and mentally competent to make this declaration.

Signed on _____ day of _______________, _____.

Signature: ____

Name: _______________

Address: ____________________

____

County:______________

STATEMENT OF WITNESSES

I declare that the person who signed or acknowledged this document has (1) identified himself or herself to me, (2) signed or acknowledged this document in my presence, (3) appears to be of sound mind, and under no duress, fraud or undue influence. I am not the person appointed as Healthcare Agent or Alternate Healthcare Agent by this document, nor am I the operator of a community care facility, or an employee of an operator of a health care facility.

I further declare that I am not related to him/her by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of him/her or entitled to any part of the estate of him/her under a will now existing or by operation of law. Each of us is at least 18 years of age.

Witness Signature: ____

Name: _____________________________________

Address: _____________________________________

____

____

Witness Signature: ____

Name: _____________________________________

Address: _____________________________________

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