

# **OKLAHOMA**

## **Advance Directive**

### **Planning for Important Healthcare Decisions**

Courtesy of CaringInfo

[www.caringinfo.org](http://www.caringinfo.org)

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **ACTION STEPS**

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or 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.

## **INTRODUCTION TO YOUR OKLAHOMA ADVANCE HEALTH CARE 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.

**Part I** of the Advance Directive is the **Living Will**. It lets you state your wishes about healthcare in the event that you can no longer make your own health care decisions and you are terminally ill, persistently unconscious, or have an end-stage condition.

**Part II** is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your healthcare.

**Part III** addresses **Anatomical Gifts**. This Part allows you to indicate whether you want to donate any or all of your organs and tissues after your death.

**Part IV** contains general provisions regarding your advance directive for health care.

**Part V** contains the signature and witnessing provisions so that your document will be effective.

You may fill out Part I, Part II, Part III, or any or all of these parts, depending on your advance planning needs. **You must complete Part V.**

### **How do I make my Oklahoma Advance Health Care 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 related to you or be any person who can inherit from your estate.

*Note: you do not need to have your Oklahoma Advance Health Care Directive notarized.*

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

Unless related by blood, marriage, or adoption, your agent may not be an owner, operator, or employee of a residential long-term care institution at which you are receiving care.

## **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

## **When does my agent's authority become effective?**

Part I, **Living Will**, goes into effect when your doctor determines that you are no longer able to make your own decisions, and that you are terminally ill, persistently unconscious, or have an end-stage condition.

Unless otherwise indicated in Part II of your advance directive, your **Power of Attorney for Health Care** becomes effective when your primary doctor determines that you lack the ability to understand the nature and consequences of your healthcare decisions or the ability to make and communicate your healthcare decisions. If you want your agent to make healthcare decisions for you now, even though you are still capable of making healthcare decisions, you can include this instruction in your power of attorney for health care designation.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

## **Agent Limitations**

Your Oklahoma Advance Directive for Health Care will not be honored if you are pregnant unless you have specifically authorized that life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn during pregnancy; and your agent will be bound by the current laws of Oklahoma as they regard pregnancy and termination of pregnancies.

## **What if I change my mind?**

You may revoke your Oklahoma Advance Directive for Health Care at any time and in any manner, regardless of your mental or physical condition. Your revocation is effective once you, or a witness to your revocation, notify your doctor or other health care provider.

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

## **What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form **MUST** be signed by a healthcare provider and **MUST** be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

**OKLAHOMA ADVANCE DIRECTIVE FOR HEALTH CARE**  
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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

**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

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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

(Attach additional pages, if needed.)

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**PART II**

PRINT THE  
NAME, ADDRESS,  
AND TELEPHONE  
NUMBER OF YOUR  
AGENT AND  
ALTERNATE AGENT

**Part II. POWER OF ATTORNEY FOR HEALTH CARE**

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 agent: \_\_\_\_\_,

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone number: \_\_\_\_\_

whom I appoint as my agent. If my agent is unable, unwilling, or not reasonably available to serve, I appoint

Name of alternate agent: \_\_\_\_\_,

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone number: \_\_\_\_\_

as my alternate agent with the same authority. My agent is authorized to make whatever medical treatment decisions I could make if I were able. However, my agent or alternate agent must make decisions consistent with any choices I have made in this document regarding life-sustaining treatment and artificially administered nutrition and hydration.

If I fail to designate an agent in this section, I am deliberately declining to designate an agent.

When making health-care decisions for me, my agent 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 agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.



© 2005 National  
Alliance for Care at  
Home. 2023  
Revised.

This image shows a full page of blank white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page, providing a guide for writing. There are no margins, text, or other markings on the paper.

(Attach additional pages, if needed.)

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

Initial the line next to the choices below that best reflect your wishes. You do not have to initial any of the choices. If you do not initial any of the choices, your power of attorney for health care, guardian, or other agent, or your family, may have the authority to make a gift of all or part of your body under Oklahoma law.

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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PART III

OPTIONAL

INITIAL ALL USES  
TO WHICH YOU  
AGREE FOR YOUR  
GIFT

INITIAL ONLY ONE

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PART IV

**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

PART V

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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**Part V. Execution**

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

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

\_\_\_\_\_  
(printed name)

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

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

Witnesses: This advance directive was signed in my presence.

Witness # 1

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(printed name)

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

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

Witness # 2

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(printed name)

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

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

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