Mt. Lebanon Internal Medicine Division
St. Clair Medical Services

Advance Directive

I, _____, being of sound mind, willfully and voluntarily make this directive to be followed if I become unable to participate in decisions regarding medical care.

If I should be in a terminal condition, in a permanent state of unconsciousness or suffer from irreversible brain damage with no hope of significant recovery, I direct my attending physician to withhold or withdraw life-sustaining treatment that only prolongs the process of my dying. I direct that treatment be limited to measures to keep me comfortable and to relieve pain.

In addition, if I am in the condition described above, I feel strongly about the following forms of treatment:

I do _____ do not _____ want cardiac resuscitation (CPR, chest compressions, electrical shock to heart).
I do _____ do not _____ want to be put on a breathing machine (ventilator).
I do _____ do not _____ want transfusion of blood or blood products.
I do _____ do not _____ want surgery or invasive tests.
I do _____ do not _____ want dialysis (machine to replace kidney function).
I do _____ do not _____ want antibiotics (to fight infections).
I do _____ do not _____ want tube feeding or intravenous nutrition (food) or hydration (water).

I realize that if I do not specifically indicate my preference regarding any forms of treatment listed above, I may receive that form of treatment. I also realize that illness may take many forms and that it is impossible to predict every circumstance. My physicians will try to follow the letter and spirit of my wishes if they are known.

Other instructions – Proxy Clause: (Check one)

I do _____ do not _____ want another person to make medical decisions on my behalf if I am unable to communicate my instructions as outlined above. I have discussed (or will discuss) my feelings with this person. I give my proxy permission to access my medical records and allow my physician to discuss my health information with my proxy:

Proxy Name: _____ Address: _____
Phone: _____
Substitute (If the first proxy is unable to serve): _____
Address: _____ Phone: _____

Patient's Signature: _____Date of directive: _____
(Sign in the presence of two witnesses at least 18 years old.)
Witness: _____ Address: _____
Witness: _____ Address: _____