End-of-Life Care Medical Directive

This directive outlines my preferences regarding end-of-life medical care, in accordance with my wishes and the laws of my state or country.

Patient Information

Full Name:

Date of Birth:

Address:

Advance Directive Choices

Life-Sustaining Treatments

I wish to receive the following treatments if I am diagnosed with a terminal condition or am permanently unconscious (check all that apply):

- ☐ Cardiopulmonary resuscitation (CPR)
- ☐ Mechanical ventilation
- ☐ Artificial nutrition and hydration
- ☐ Dialysis
- ☐ Other life-sustaining treatments: _____

Pain Management & Comfort Care

☐ I wish to receive medication or other comfort care to relieve pain and suffering, even if it may hasten my death.

Health Care Agent (Optional)

Name of Agent:

Telephone:

Relationship to Patient:

Additional Instructions

Patient Signature:

Date:

Witness/Notary Signature:

Date: