Instruction Directive for Life-Sustaining Treatment

Patient Information

Full Name

Date of Birth

Address

Phone

Treatment Preferences

- [ ] Cardiopulmonary Resuscitation (CPR)
- [ ] Mechanical Ventilation
- [ ] Artificial Nutrition & Hydration
- [ ] Dialysis

Other Instructions

Statement of Preferences

Please state your wishes regarding life-sustaining treatment:

Health Care Representative

Representative Name

Representative Phone

Relationship

Signature

Patient Signature

Date

Witness (if required)

Name

Date