INSTRUCTIONS

NEW YORK HEALTH CARE PROXY

PRINT YOUR NAME

(1) I, ______________________________________, hereby appoint:
(name)

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT

____
(name, home address and telephone number of agent)

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. **My agent does know my wishes regarding artificial nutrition and hydration.**

This Health Care Proxy shall take effect in the event I become unable to make my own health care decisions.

ADD PERSONAL INSTRUCTIONS (If Any)

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.

PRINT NAME, AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

____
(name, home address and telephone number of alternate agent)

____

ORGAN DONATION (OPTIONAL)

(4) Donation of Organs at Death: Upon my death:

[ ] I **do not** wish to donate my organs, tissues or parts.
[ ] I **do** wish to be an organ donor and upon my death I wish to donate:

(Continued)

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ORGAN DONATION (OPTIONAL) *CONTINUED*

[ ] (a) Any needed organs, tissues, or parts; **OR**

[ ] (b) The following organs, tissues, or parts

____

____

[ ] (c) My gift is for the following purposes:
(put a line through any of the following you do not want)

(i) Transplant

(ii) Therapy

(iii) Research

(iv) Education

ENTER A DURATION OR A CONDITION (IF ANY)

(5) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

____

____

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

(6) Signature __________________________________ Date _______________

Address ____

WITNESSING PROCEDURE

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as proxy by this document

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1 ____

Address____

Witness 2 ____

Address ____

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INSTRUCTIONS

NEW YORK LIVING WILL

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case In re Westchester County Medical Center, 72 N.Y.2d 517 (1988). In that case the Court established the need for "clear and convincing" evidence of a patient's wishes and stated that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will.'"

PRINT YOUR NAME

I, ____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an **incurable or irreversible mental or physical condition with no reasonable expectation of recovery,** including but not limited to: (a) **a terminal condition**; (b) **a permanently unconscious condition**; or (c) **a minimally conscious condition in which I am permanently unable to make decisions or express my wishes**.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments **if I am in the condition(s) described above I feel especially strongly about the following forms of treatment**:

CROSS OUT ANY STATEMENTS THAT DO NOT REFLECT YOUR WISHES

I do not want cardiac resuscitation.
I do not want mechanical respiration.
I do not want artificial nutrition and hydration.
I do not want antibiotics.

However, I **do want** maximum pain relief, even if it may hasten my death.

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ADD PERSONAL INSTRUCTIONS (IF ANY)

Other directions:

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed ____ Date _____________

Address ____

WITNESSING PROCEDURE

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1 ____

Address ____

Witness 2 ____

Address ____

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State of New York
Department of Health

Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name____________________________

Date of Birth __ / __ / __

Do not resuscitate the person named above.

Physician's Signature_______________

Print Name ______________________

License Number ________________

Date __ / __ / __

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

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