Advanced Healthcare Directive

Date: [Insert Date]

Patient Information

Name: [Insert Full Name]

Date of Birth: [Insert Date of Birth]

Address: [Insert Address]

Healthcare Agent

Name: [Insert Agent Name]

Relationship: [Insert Relationship]

Contact Number: [Insert Contact Number]

Healthcare Wishes

I, [Insert Full Name], hereby state my wishes regarding medical treatment in the event that I become unable to communicate my decisions.

1. Life-Sustaining Treatment

[Specify your wishes regarding life-sustaining treatments such as resuscitation, mechanical ventilation, and feeding tubes.]

2. Pain Relief

[Specify your wishes regarding the use of pain relief medications.]

3. Organ Donation

[Express your wishes regarding organ donation.]

Signature

_____

[Insert Full Name]

Witness Information

Witness 1 Name: [Insert Witness Name]

Witness 1 Signature: _____

Witness 2 Name: [Insert Witness Name]

Witness 2 Signature: _____