

OREGON

Advance Directive

Planning for Important Healthcare Decisions

Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #11241.

**Support for this program is provided by a grant from
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New Jersey.**

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Your Advance Care Planning Packet

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Using these materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.
4. Read all the instructions, on pages 8 through 10, as they will give you specific information about the requirements in your state.
5. Refer to the Glossary located in Appendix A if any of the terms are unclear.

ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
8. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
9. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
 - File a complaint with your provider or health insurer, or
 - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as by reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

INTRODUCTION TO YOUR OREGON ADVANCE DIRECTIVE

This packet contains a legal document, the **Oregon Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part A of your Oregon Advance Directive contains important information that you should read before completing your document.

Part B of your Oregon Advance Directive is the **Appointment of Healthcare Representative**. This section lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Appointment of Healthcare Representative is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part C of your Oregon Advance Directive is for **Healthcare Instructions**. This section functions as a living will. It lets you state your wishes about medical care in the event that you are in a terminal condition, are permanently unconscious, or have an advanced progressive illness and can no longer make your own medical decisions. (One other physician must agree with your attending physician's opinion of your medical condition.)

Note: This document will be legally binding only if the person completing it is a competent adult (at least 18 years old), an emancipated minor, or is married.

INTRODUCTION TO YOUR OREGON ADVANCE DIRECTIVE (CONTINUED)

How do I make my Oregon Advance Directive legal?

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses, neither of whom may be your attending physician or your healthcare representative or alternate. Your witnesses must also sign the document to show that they personally know you or have been provided with proof of your identity, that you signed or acknowledged your signature in their presence, that you appear to be of sound mind and free of duress, fraud or undue influence, and that they are neither your attending physician nor your healthcare representative or alternate.

At least one of your witnesses **cannot** be:

- related to you (by blood, marriage or adoption),
- entitled to any portion of your estate under any will or by operation of law, or
- an owner, operator or employee of your treating healthcare facility.

If you are a patient in a long-term care facility, one of your witnesses must be a person designated by your facility and qualified under the rules of the Department of Human Resources.

Note: You do not need to notarize your Oregon Advance Directive.

What if I change my mind?

You can revoke your Oregon Advance Directive at any time and in any manner by which you are able to communicate your intent to revoke your document. Your revocation becomes effective once you notify your doctor or healthcare provider or your healthcare representative. If you notify your healthcare representative, he or she must promptly inform your doctor or healthcare provider of your revocation if you are unable to do so. Once your doctor or healthcare provider is notified of your revocation, he or she must make it part of your medical record.

Your Oregon Advance Directive will automatically be revoked if you execute a new Oregon Advance Directive, unless you have specified otherwise in your document.

COMPLETING PART B: APPOINTMENT OF HEALTHCARE REPRESENTATIVE

Whom should I appoint as my healthcare representative?

Your healthcare representative is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your representative can be a family member or a close friend whom you trust to make serious decisions. The person you name as your representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A healthcare representative may also be called an “agent,” “proxy” or “attorney-in-fact.”)

Unless he or she is related to you by blood, marriage or adoption, the person you appoint as your healthcare representative **cannot** be:

- your attending physician or an employee of your attending physician, or
- an owner, operator or employee of a healthcare facility in which you are a patient or resident, unless you appointed him or her as your representative before your admission to the facility.

You can appoint a second person as your alternate healthcare representative. The alternate will step in if the first person you name as representative is unable, unwilling or unavailable to act for you.

Should I add personal instructions to Part B of my Oregon Advance Directive?

If you want your healthcare representative to have the power to make decisions about life-sustaining treatment and artificial nutrition and hydration on your behalf, you must initial the statements under numbers 2 and 3 in Part B of your Oregon Advance Directive. If you do not initial these statements, your representative will be unable to make decisions on your behalf concerning life-sustaining treatment and artificial nutrition and hydration.

One of the strongest reasons for naming a healthcare representative is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions here, you might unintentionally restrict your representative’s power to act in your best interest.

Talk with your representative about your future medical care and describe what you consider to be an acceptable “quality of life.” If you want to record your wishes about specific treatments or conditions, you should use part C of your Oregon Advance Directive (the living will section).

COMPLETING PART B: APPOINTMENT OF HEALTHCARE REPRESENTATIVE (CONTINUED)

What other important facts should I know?

- Part B of your Advance Directive (Appointment of Healthcare Representative) will not be valid unless your healthcare representative and alternate sign and date the acceptance statement on page 7 of your document.
- If you appoint your spouse as your healthcare representative, the appointment is automatically revoked if you petition for divorce or annulment, unless you reaffirm your representative's appointment at that time.
- Your healthcare representative is not authorized to make healthcare decisions with respect to any of the following: (1) admission or retention in a mental healthcare facility; (2) convulsive treatment; (3) Psychosurgery; (4) sterilization; (5) abortion; or (6) withholding or withdrawing life-sustaining procedures unless given authority to do so.

COMPLETING PART C: HEALTHCARE INSTRUCTIONS

Can I add personal instructions to Part C of my Oregon Advance Directive?

Yes. Part C has been designed to allow you to personalize your Oregon Advance Directive. Sections 1 to 5 present specific situations in which decisions about life-sustaining treatment and artificial nutrition and hydration may need to be made. You should initial the statements that reflect your wishes. Unless you clearly outline the situations in which you would not want to receive artificial nutrition and hydration or life-sustaining treatment, your doctor may not be able to withhold or withdraw artificial feeding or life-sustaining treatment from you.

In addition, you can add personal instructions in section 6 of Part C, called "Additional Conditions or Instructions."

If you have appointed a healthcare representative under Part B of your Advance Directive, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Advance Directive are to be decided by my agent."

OREGON ADVANCE DIRECTIVE – PAGE 1 OF 7

INSTRUCTIONS

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C (Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so. If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

Name _____ Birth date _____

Address _____

Unless revoked or suspended, this advance directive will continue for:
INITIAL ONE: _____ My entire life _____ Other period (_____ Years)

PRINT YOUR NAME,
ADDRESS AND DATE
OF BIRTH

INITIAL HERE

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PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF YOUR
REPRESENTATIVE

I appoint _____
(name of health care representative)

as my health care representative. My representative's address is _____

_____ and telephone number is _____.

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF YOUR
ALTERNATE
REPRESENTATIVE

I appoint _____
(name of alternate health care representative)

as my alternate health care representative. My alternate's address is _____

_____ and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. LIMITS.
Special Conditions or Instructions:

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

INITIAL IF APPLIES

INITIAL IF THIS APPLIES:

____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

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INITIAL IF APPLIES

2. LIFE SUPPORT.

"Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

___ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

INITIAL IF APPLIES

3. TUBE FEEDING.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

___ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

Date: _____

SIGNATURE OF PERSON MAKING APPOINTMENT

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

(signature of person making appointment)

INSTRUCTIONS

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in Part B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

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Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. CLOSE TO DEATH.

If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

2. PERMANENTLY UNCONSCIOUS.

If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

3. ADVANCED PROGRESSIVE ILLNESS.

If I have a progressive illness that will be fatal and the illness is in an advanced stage, and I am consistently and permanently unable to communicate, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

INITIAL ONE

INITIAL ONE

INITIAL ONE

INITIAL ONE

INITIAL ONE

INITIAL ONE

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4. EXTRAORDINARY SUFFERING.

If life support would not help my medical condition and would make me suffer permanent and severe pain:

INITIAL ONE

A. INITIAL ONE:

___ I want to receive tube feeding.

___ I want tube feeding only as my physician recommends.

___ I DO NOT WANT tube feeding.

INITIAL ONE

B. INITIAL ONE:

___ I want any other life support that may apply.

___ I want life support only as my physician recommends.

___ I want NO life support.

INITIAL IF APPLIES

5. GENERAL INSTRUCTION.

INITIAL IF THIS APPLIES:

___ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

ANY ADDITIONAL
CONDITIONS ON
INSTRUCTION

6. ADDITIONAL CONDITIONS OR INSTRUCTION.

(Insert description of what you want done.)

ORGAN DONATION

7. ORGAN DONATION (OPTIONAL)

(Under Oregon law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research, or for the advancement of medical or dental science. You may also authorize your agent to do so, or if you do not have a designated agent a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift.)

If any of the statements below reflects your desire, initial on the line next to that statement. If you do not initial any of the statements, your agent, or if you do not have an agent or your agent is not authorized to make a gift, your family will have the authority to make a gift of all or part of your body under Oregon law.

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

_____ Pursuant to Oregon law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following parts or organs listed below:

I give these organs or parts for (initial one or more):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes.

_____ Research or educational purposes

8. OTHER DOCUMENTS.

A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect.

_____ I have a health care power of attorney, and I REVOKE IT.

_____ I DO NOT have a health care power of attorney.

DATE AND SIGN

Date: _____

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(signature)

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed or acknowledged that person's signature on this advance directive in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Has not appointed either of us as health care representative or alternative representative; and
- (e) Is not a patient for whom either of us is attending physician.

Witnessed by:

WITNESS # 1

(signature of witness)

(date)

(printed name of witness)

WITNESS # 2

(signature of witness)

(date)

(printed name of witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

**PART E:
ACCEPTANCE BY HEALTH CARE REPRESENTATIVE**

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest.

OREGON ADVANCE DIRECTIVE — PAGE 7 OF 7

SIGNATURE OF
HEALTH CARE
REPRESENTATIVE

(signature of health care representative) (date)

(printed name)

SIGNATURE OF
ALTERNATE
HEALTH CARE
REPRESENTATIVE

(signature of alternate health care representative) (date)

(printed name)

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*Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

YOU HAVE FILLED OUT YOUR ADVANCE DIRECTIVE, NOW WHAT?

1. Your Oregon Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your healthcare representative and alternate, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your healthcare representative and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your document after it has been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your Oregon document.
6. Be aware that your Oregon document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**

Appendix A

Glossary

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Brain death – The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

Emergency Medical Services (EMS): A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Healthcare agent: The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

Hospice - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

Intubation- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-sustaining treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

Living will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "healthcare declaration," or "medical directive."

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

Medical power of attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

Palliative care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

Power of attorney – A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

Respiratory arrest: The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate decision-making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

Ventilator – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Appendix B

Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives

LEGAL SERVICES

The Oregon Department of Human Services website provides information and resources on some of the most important legal issues and documents for individuals over 60 and individuals who have disabilities.

The website can assist individuals with legal information and services and issues that include:

- Power of Attorney
 - Wills and trusts
 - Guardians and Conservators
 - Disability issues and more
-
- Must be 60 and older and have a disability
 - Free for individuals with low to moderate incomes

For more information and legal assistance call toll free:

1-800-282-8096 or 1-503-945-5811

OR

Visit their website:

<http://www.oregon.gov/DHS/spd/legal.shtml>

END-OF-LIFE SERVICES

The Oregon Department of Health and Human Service can connect individuals over the age of 60 with an Area Agency on Aging (AAA) in their region who can assist them with services in their area.

AAA resources and services include, but are not limited to:

- Housing
 - Healthcare
 - Legal services
 - Transportation
 - Meals and more
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- Must be 60 and older
 - Free to individuals with low to moderate incomes

Visit their website to locate AAA in your area for information about services:

<http://www.oregon.gov/DHS/spwpd/offices.shtml>

OR

Call toll free: 800-282-8096 or 1-503-945-5811