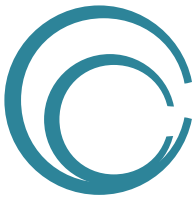

compassion & choices

Care & Choices at the End of Life.

Advance Directive

Planning for Important Healthcare Decisions

Massachusetts

Massachusetts Healthcare Proxy

(1) I, _____, hereby appoint
(name)

_____

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

as my healthcare agent to make any and all healthcare decisions for me, except to the extent that I state otherwise below.

This Healthcare Proxy shall take effect in the event I become unable to make or communicate my own healthcare decisions.

(2) Name of alternate agent if the person I appoint above is unable, unwilling or unavailable to act as my healthcare agent (optional):

_____

_____

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

(3) I direct my agent to make healthcare decisions in accord with my wishes and limitations as may be stated below, or as he or she otherwise knows. If my wishes are unknown, I direct my agent to make healthcare decisions in accord with what he or she determines to be my best interests.

(4) Other directions (optional):

(Continued)

(5) Signature: _____ Date: _____

Address: _____

Statement by Witnesses

I declare that the person who signed this document appears to be at least 18 years of age, of sound mind, and under no constraint or undue influence. 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 agent or alternate agent by this document.

Witness 1: _____

Address: _____

_____

Date: _____

Witness 2: _____

Address: _____

_____

Date: _____

Living Will

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 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:**

I do not want cardiac resuscitation.
I do not want mechanical respiration.
I do not want tube feeding.
I do not want antibiotics.

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

Other directions (insert personal instructions):

(Continued)

These directions express my legal right to refuse treatment under federal and state law. I intend my instructions to be carried out, unless I have revoked them in a new writing or by clearly indicating that I have changed my mind.

Signed: _____ Date: _____

Address: _____

_____

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.

Witness: _____

Address: _____

_____

Witness: _____

Address: _____

_____

P. O. Box 101810
Denver, CO 80250

tel 800.247.7421
fax 866.312.2690