

## Indiana Health Care Representative Will to Live Form

This type of document has been authorized by the Indiana Health Care Consent Act, Ind. Code Ann. §§16-36-1-1 through 16-36-1-14. This document is not intended to be a will or a declaration under Ind. Code Ann. §§ 16-36-4-10 or 16-36-4-11.

I, (your name) \_\_\_\_\_

(your address) \_\_\_\_\_

(your phone number) \_\_\_\_\_

appoint:

(Name of agent) \_\_\_\_\_

(address of agent) \_\_\_\_\_

(phone number(s) of agent) \_\_\_\_\_

as my health care representative to make any health care decisions for me as authorized in this document consistent with the instructions below.

If the person I appoint above refuses or is not able to act for me, I appoint the following persons (each to act alone and successively, in the order named):

First Successor Representative

(successor's name) \_\_\_\_\_

(successor's address) \_\_\_\_\_

(successor's phone number) \_\_\_\_\_

Second Successor Representative

(second successor's name) \_\_\_\_\_

(second successor's address) \_\_\_\_\_

(second successor's phone number) \_\_\_\_\_

as my health care representative(s) to make health care decisions for me as authorized in this document consistent with the instructions below.

This appointment shall become effective only when I become incapable of making and communicating my own health care decisions.

Any prior appointment is revoked.

### **GENERAL PRESUMPTION FOR LIFE**

I direct my health care provider(s) and health care representative(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care representative to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care representative to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my health care representative, as named below, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

**WHEN MY DEATH IS IMMINENT**

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

**(Be as specific as possible; SEE SUGGESTIONS.):**

---

---

---

---

---

---

---

---

(Cross off any remaining blank lines.)

**WHEN I AM TERMINALLY ILL**

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

**(Be as specific as possible; SEE SUGGESTIONS.):**

---

---

---

---

---

---

---

---

(Cross off any remaining blank lines.)

**C. OTHER SPECIAL CONDITIONS:**

**(Be as specific as possible; SEE SUGGESTIONS.):**

---

---

---

---

---

---

---

---

(Cross off any remaining blank lines.)

**IF I AM PREGNANT**

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care representative(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

\_\_\_\_\_

Signature of Declarant

To the extent, but only to the extent, withholding or withdrawal of health care is directed or authorized in (A) , (B) , OR ( C ) above, the provisions<sup>1</sup> in the following box apply:

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Signature of Principal)

Address \_\_\_\_\_

\_\_\_\_\_

<sup>1</sup> The exact language in this box is required by Ind. Code. Ann. § 16-36-1-14 (b) and § 30-5-5-17 (a).

*Complete only if principal is physically unable to sign:*

I have signed the principal's name above at his/her direction in the presence of the principal and a witness.

Name \_\_\_\_\_

Address \_\_\_\_\_

**WITNESS**

In my presence, the principal, who appeared to be at least eighteen years of age, of sound mind and under no constraint or undue influence, signed this Health Care Proxy this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Signature of Witness)

Address \_\_\_\_\_