# ADVANCE DIRECTIVE FOR HEALTH CARE (SHORT FORM)

**FOR:** _____

**(PATIENT'S NAME)**

In order to assist my Health Care Representative in making health care decisions for me as easily and confidently as possible, I leave these specific instructions to supplement my Advance Directive for Health Care and Health Care Representative appointment, or any other document appointing a Health Care Representative, or other document stating my wishes, or any individual whom I have selected who is serving as my Health Care Representative, or by law if no one is appointed by me, or my Health Care Representative authorized or as granted by a court of Law. Any decisions stated herein will supersede any previously dated document that conflicts with my wishes and decisions stated in this document.

If my treating physician or other licensed health care provider has determined with reasonable certainty that I am terminally ill or in a persistent and irreversible coma:

**SELECT A CHOICE BELOW:**

**DO_____** **DO NOT _____** If I have no pulse and if am not breathing, attempt resuscitation (DNR).

**YES_____** **NO _____** Maximize my comfort through symptom management and relieve my pain and suffering through available measures, including the administration of medication to me through any route.

**DO_____** **DO NOT _____** Provide artificial nutrition (tube feeding) or hydration to me, except for the provision of fluids to the extent necessary to deliver pain medication.

I would like to state my healthcare preferences as below to explain above selections or any other preferences for my healthcare:

_____

_____

_____

_____

_____

_____

**IN WITNESS WHEREOF**, I have signed my name on this _____ day of _____, 20__.

_____
**(SIGNATURE)**

_____
**(PRINTED)**

STATE OF INDIANA )

COUNTY OF _____ )

On the _____ day of _____ 20__, before me, the undersigned, a Notary Public in and for said County and State, personally appeared _____ known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that said person executed the same.

WITNESS my hand and official seal.

_____ My Commission Expires: _____
Notary Public Signature

_____ My County of Residence: _____
Printed

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security Number in this document, unless required by law. Glenn A. Deig, #13953-82

**This instrument prepared by:**

**Glenn A. Deig, #13953-82**
**Certified Elder Law Attorney by the National Elder Law Foundation**
**Certified as an Estate Planning and Administration Specialist**
**By the Indiana State Bar Association**
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