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**Montana Department of Justice**
**Office of Consumer Protection**
**MONTANA**
**END-OF-LIFE REGISTRY**
https://dojmt.gov/consumer/end-of-life-registry/

# My Choices Advance Directive

For office use only

PO Box 201410, Helena, MT 59620-1410 • Phone: (406) 444-0660 or (866) 675-3314 • E-mail: endofliferegistry@mt.gov

**Full Name:** _____
Please print

These directions apply only in situations when I am not able to make or communicate my health care choices directly. Put an X through any sections you are not completing at this time.

## 1. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if both of the following two conditions exist:

- **I have a terminal condition, and**
- **in the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment that only prolongs the dying process.**

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

### General Treatment Directions

Check the boxes that express your wishes:

☐ I provide no directions at this time.

☐ I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

I further direct that (check all boxes that apply):

☐ Treatment be given to maintain my dignity, keep me comfortable and relieve pain.

☐ If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.

☐ If I cannot eat, I do not want a tube inserted in my nose or mouth, or surgically placed in my stomach to give me food.

☐ If I have a serious infection, I do not want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.

I have attached additional directions regarding medical treatment to this form:

☐ Yes ☐ No

## 2. Chronic Illness or Serious Disability (Optional)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

Diagnosis _____

Consult my physician _____
Name Phone

Special directions (use additional pages if necessary) _____

## 3. Health Care Representative (Power of Attorney for Health Care)

My Representative may make all health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

**I wish to appoint a Representative** ☐ Yes ☐ No

### A. Primary Representative

I appoint _____ as my Representative.
Print Representative's Full Name

_____
Representative's Address

_____
City State Zip

_____
Home Phone Work Phone

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

### B. Alternate Representative(s)

If: 1. I revoke my Representative's authority; or
2. My Representative becomes unwilling or unable to act for me; or
3. My Representative is my spouse and I become legally separated or divorced,

I name the following person(s) as alternates to my Representative in the order listed:

**1.** _____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

**2.** _____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

# 4. Signing and Witnessing this Advance Directive

## A. Your Signature

Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the _____ day of _____, 20_____

_____ _____
Signature Print Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

## B. Ask Your Witnesses to Read and Sign

I declare that I am over the age of 18 and the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud or undue influence.

**1.** _____
Signature Date

_____
Printed Name

_____
Address

_____
City State Zip

**2.** _____
Signature Date

_____
Printed Name

_____
Address

_____
City State Zip

## C. Notarizing This Document

STATE OF _____ COUNTY OF _____

On this _____ day of _____, 20____, the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

_____

_____

Notary Public for the State of _____

Residing at _____

My commission expires _____

## 5. Special Directions

**A. Spiritual Preferences**

My religion _____ My faith community _____

Contact person _____ I would like spiritual support ☐ Yes ☐ No

**B. Where I Would Like to be When I Die**

☐ My home ☐ Hospital ☐ Nursing home ☐ Other _____

**C. Donation of Organs at My Death** (check one of the following):

☐ I do not wish to donate any of my body, organs, or tissue.

☐ I wish to donate my entire body.

☐ I wish to donate **only** the following (check all that apply):

☐ Any organs, tissues, or body parts ☐ Heart ☐ Kidneys ☐ Lungs

☐ Bone Marrow ☐ Eyes ☐ Skin ☐ Liver ☐ Other(s)

**D. After-Death Care** (care of my body, burial, cremation, funeral home preference)

_____

**E. Additional Directions** (use additional pages if necessary) _____

_____

**Signature** _____ **Date** _____

**F. Distributing this Advance Directive**

**I plan to deposit this Advance Directive in the Montana End-of-Life Registry:** ☐Yes ☐No

I plan to send copies of this document to the following people or locations:

**Physician:**

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

**Family Member:** Relationship _____

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

**Hospital:**

_____
Name

_____
Address

_____
City State Zip

_____
Phone

**Clergy:**

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone