HEALTH CARE DIRECTIVE
(please type or print legibly)

THIS IS THE HEALTH CARE DIRECTIVE OF:

NAME_____

ADDRESS_____
CITY_____ PROVINCE_____TELEPHONE_____

PART ONE: DESIGNATION OF A HEALTH CARE PROXY

In this part, you may name one or more person(s) who will have the power to make decisions concerning your medical treatment when you lack the ability to make those decisions yourself. If you do not wish to name a Proxy, you may skip this part.

NAME OF FIRST PROXY_____
ADDRESS_____
CITY_____ PROVINCE_____TELEPHONE_____

NAME OF SECOND PROXY (optional)_____
ADDRESS_____
CITY_____ PROVINCE_____TELEPHONE_____

If I have named more than one proxy, I wish them to act:___consecutively ___jointly (initial or check your choice) If you do not, Proxy #2 will be deemed to act only if Proxy #1 cannot or will not act.

I place no restrictions on the ability of my Health Care Proxy to make medical or treatment decision on my behalf when I lack the capacity to do so for myself, except as follows:_____
_____

PART TWO: TREATMENT INSTRUCTIONS

In this part, you may set out your instructions concerning medical treatment which you do or do not wish to receive, and the circumstances in which you do or do not wish to receive this treatment. Remember that your instructions can only be carried out if they are set out clearly and precisely. If you wish to use the reverse side of this form or if you wish to add additional pages to this part, indicate so clearly and sign or initial each such additional page. If you do not wish to express any treatment instructions, you make skip this part.

_____
_____

PART THREE: SIGNATURE AND DATE

In order to be valid this Health Care Directive must be dated and signed by you. No witness is required.

SIGNATURE_____ DATE_____

If you are unable to sign yourself, you may have someone other than a family member sign on your behalf. In that case the substitute must sign in your presence and in the presence of a witness. The Proxy or the Proxy's spouse cannot be the sibstitute signer or the witness.

NAME OF SUBSTITUTE:_____ ADDRESS_____
SIGNATURE _____ DATE_____
NAME OF WITNESS _____ ADDRESS_____
SIGNATURE_____ DATE_____

ATTACHED TO AND FORMING PART OF THE HEALTH CARE DIRECTIVE OF _____

SIGNATURE_____ DATE_____

	I want this treatment	I want treatment tried If no clear improvement, stop	I am undecided	I DO NOT want this treatment
Cardiopulmonary resuscitation At the point of death, using drugs and electric shock to keep the heart beating, artificial breathing				
Mechanical Breathing Breathing by machine				
Invasive Diagnostic Tests Such as using a flexible tube to look into the stomach or other organs or places				
Major Surgery Such as removal and/or replacement of organs (eg. Gall bladder, stomach or intestines, kidney, etc) heart or lung surgery etc.				
Minor Surgery Such as removal of some tissue to prevent or check infection, biopsies, etc.				
Kidney Dialysis Cleaning the blood by machine by fluid passed through the belly				
Chemotherapy or Radiotherapy Using drugs or radiation to treat cancer				
Artificial Nutrition and Hydration Giving nutrition and fluid through a tube in the veins, nose or stomach				
Blood or Blood Products Such as giving transfusions				
Antibiotics Using drugs to treat infections				
Simple Diagnostic Tests Such as performing blood tests or x-rays				
Pain Medication Using drugs even if they dull consciousness and/or indirectly shorten life				