ADVANCE MEDICAL DIRECTIVE

Personal details

This Advance Medical Directive (Living Will) and Healthcare Attorney Authorisation is made by me:

Full name	
Gender	
Date of Birth	DD/MM/YY
Government ID	1. Document Name: 2. ID No.:
Full permanent residential address	
Full current residential address:	
Municipality/Panchayat	

If and when the time comes that I can no longer participate in decision-making regarding my own health and medical treatment, this directive should be treated as the final expression of my wishes.

[If you wish, you may provide more details about why you wish to make this directive, and any beliefs and values that you wish to be taken note of and respected during decision-making on your behalf]

I request that all concerned (including my named Healthcare Power of Attorneys, my treating team, and others involved) must treat my wishes in this document as the primary basis for any decision regarding my medical treatment, particularly decisions relating to life-sustaining treatment.

Directions relating to life-sustaining treatment

In situations where my treating physician or team have determined that:

- There is no reasonable medical probability of recovery from a terminal condition, end-stage condition,[1] or vegetative state;[2] and

[1] 'End-stage condition' means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

[2] 'Vegetative state' is one where a person is awake but does not show any signs of awareness. A person is unlikely to recover when they have been in a vegetative state for more than 6 months (if caused by a non-traumatic brain injury) or more than 12 months (if caused by a traumatic brain injury). *(Source: The National Health Services, The United Kingdom)*

- Any further medical intervention or course of treatment would only serve the purpose of artificially prolonging the process of dying,

I direct that any life-prolonging medical procedure/treatment be withheld or withdrawn, and the course of natural death be permitted.

[Here, it is not necessary to do so, but you may provide specifics of health conditions that you anticipate, and/or the kind of life-sustaining treatment you would like to be withheld or withdrawn for each of these conditions. You may mention one or more points in the list below, to indicate what you want or do not want (e.g. you may refuse ventilation but want cardio-pulmonary resuscitation):

Specifically, I direct the withholding or withdrawal of the following medical procedures or forms of treatment:

1. Cardio-pulmonary resuscitation
2. Intravenous fluids and medications including antibiotics; excluding those that would provide comfort or relieve suffering/pain
3. Dialysis
4. Ventilation or other kinds of artificial life support
5. Chemotherapy
6. Radiotherapy
7. Surgery, unless it is for symptom control or to improve the quality of my life
8. Artificial administration of nutrition and hydration through means such as intubation, if it serves to only artificially prolong the process of dying (unless it is provided as part of symptom control or for improving the quality of my life).

I direct the following medical procedures or forms of treatment to be provided or continued: Cardio-pulmonary resuscitation

1. Intravenous fluids and medications including antibiotics; excluding those that would provide comfort or relieve suffering/pain*]*

Further, even when life-sustaining treatment is withheld/withdrawn, I direct the administration of medication or the performance of medical procedures for providing me with comfort care/ palliative care, or to alleviate suffering in the form of pain, distress, or mental confusion [or to facilitate organ or body donation].

Wishes or desires during end-of-life-care

[This section is entirely optional, but you may choose to add what you do want in these situations. Some examples are provided below]

- ***[Choice of place of treatment]*** For the duration of end-of-life-care, I wish to stay in a hospital or appropriate medical facility OR in a hospice or similar institution OR at home for the duration of such palliative/comfort care.

  OR

  [You can also name your preferred institution(s)] Subject to feasibility as determined by my named Healthcare Power of Attorneys, I wish to stay in [name(s) of institution] for the duration of such palliative/comfort care.
- ***[Choice of treating physician]*** I would like [name of physician, designation, name of institution] to take care of my healthcare at this stage, subject to availability and feasibility.

- *[You can mention any special focus/priority]* In the course of end-of-life-care, I wish for special attention towards alleviating mental distress or confusion, so that I am able to spend meaningful time with my loved ones.
- ***[Specifying gender identity]*** Through the course of treatment, I would like my name [specify name] and gender [specify gender and/or pronouns] to be respected by all health workers, caregivers, support staff, and others. This would be especially crucial for all forms of documentation, communication with me, communication about me with others, handling of my body, etc.
- ***[For non-heteronormative relationships]*** I would like [name of partner] to be referred to as [my partner or chosen term] in all communication by health workers, caregivers, support staff, and others.

Authorisation of Healthcare Power of Attorneys

In order to ensure that my wishes here are the primary basis for taking any treatment decisions, and to make decisions on my behalf for my medical treatment as may be needed from time to time, I have nominated [Number in words (number in figures)] Healthcare Power of Attorneys (HC-PoA) in order of preference.

[*You should authorise at least two persons to be your Healthcare Power of Attorneys. If you wish to authorise more than two persons, you should list your order of preference.*]

I have had extensive discussions with those named regarding my wishes, their responsibilities, and the situations that they may be expected to take decisions in. They have expressed that they are willing to be nominated as my Healthcare Power of Attorneys.

I authorise my Healthcare Power of Attorneys to exercise the following powers:

- They can obtain medical information from the treating team regarding my treatment, my health records, and any communications with the treating team;
- They can take decisions and act on my behalf regarding my wishes in this document as necessary. These decisions would include, but are not limited to, providing consent, refusing, or withdrawing consent to any care, treatment, service, or procedure, guided primarily by my wishes as expressed in this directive.

The decisions taken by my Healthcare Power of Attorneys should be respected regardless of any contrary views that any other person may hold.

I authorise the following person as my **Primary** Healthcare Power of Attorney**.**

Sr No	Particulars	Information
a	Full Name	
b	Relationship with the executor	
c	Date of Birth	DD/MM/YY
e	Government ID	1. Document name: 2. ID no.:
f	Mobile Number(s)	1. Primary: 2. Any other:
g	Email ID(s)	1. Primary: 2. Any other:
h	Permanent Residential Address	

Sr No	Particulars	Information
i	Residential Address on the date of signing this document	

If my Primary Healthcare Power of Attorney is not available, or unable or unwilling to take a decision, then I authorise the following persons to act as my Healthcare Power of Attorney in this order of preference:

1.

Sr No	Particulars	Details
a	Full Name	
b	Relationship with the executor	
c	Date of Birth	DD/MM/YY
e	Government ID	1. Document name: 2. ID no.:
f	Mobile Number(s)	1. Primary: 2. Any other:
g	Email ID(s)	1. Primary: 2. Any other:
h	Permanent Residential Address	
i	Residential Address on the date of signing this document	

2. [*Optional*]

Sr No	Particulars	Details
a	Full Name	
b	Relationship with the executor	
c	Date of Birth	DD/MM/YY
e	Government ID	1. Document name: 2. ID no.:
f	Mobile Number(s)	1. Primary: 2. Any other:
g	Email ID(s)	1. Primary: 2. Any other:

Sr No	Particulars	Details
h	Permanent Residential Address	
i	Residential Address on the date of signing this document	

Directions to be followed upon my death

[This section is entirely optional, but you may choose to add what you do want in these situations. Some examples are provided below]

- ***[Reference to organ donation etc.]*** I am a registered organ donor in accordance with the Transplantation of Human Organs and Tissues Act, 1994. My choices as organ donor have been noted in Form 7 of the Act, as per prescribed procedure. I am enclosing the form with this document for reference and implementation. My loved ones, including my Healthcare Power of Attorneys, have been informed of my wishes regarding organ donation.
- ***[Body/cadaver donation]*** I wish for my body to be donated for the purpose of medical research and education. In this regard, I have communicated my wish to [name of medical college or body donation NGO], submitted the necessary consent forms, and completed the relevant procedure on my part. My loved ones, including my Healthcare Power of Attorneys, have been informed of my wishes regarding body donation.
- ***[Wishes pertaining to last rites/funeral - especially important for atheists or those with chosen religions]*** I would like my last rites to be performed in accordance with practices of [name of religion] OR I would not like any religious rituals to be performed upon my death. I wish for my mortal remains to be cremated/buried/[any other process] upon completion of all necessary medical or legal procedures.

Declaration (Mandatory)

I declare that at the time of signing and executing this document,

- [*Please add this first point in case the executor is illiterate*] This document has been drafted as per my directions and its contents have been read out to me.
- I have the capacity and competence to understand the meaning and implications of everything mentioned in this document;
- I have given careful thought and consideration to everything mentioned in this document;
- I have willingly and voluntarily articulated and consented to everything mentioned in this document, without any coercion, duress, or undue influence from any person or entity.

This directive is executed in accordance with the order dated January 24, 2023 of the Hon'ble Supreme Court of India in MA No. 1699/ 2019 in WP (C) No. 215/ 2005 (SC Order). Further, a copy of this directive and healthcare power of attorney has been forwarded to:

- Healthcare Power of Attorney(s) mentioned in this directive

- [Name of family/chosen physician - optional]
- The Competent officer/custodian of the [relevant local government - panchayat, municipality, district administration, municipal corporation, etc.] *[It is necessary to send the executed AMD to the custodian, but it is optional to mention this here]*

Validity of Directive

I declare that this Directive, and my authorisations for Healthcare Power of Attorneys shall be valid and remain in force throughout my lifetime, unless I modify or revoke it.

In any case, I reserve the right to execute a revised version of this document, which makes changes to my directions/wishes, or revoke this document in its entirety. I shall also share copies of the revised version with:

- Healthcare Power of Attorney(s) mentioned in this directive
- [Name of family/chosen physician - optional]
- The Competent officer/custodian of the [relevant local government - panchayat, municipality, district administration, municipal corporation, etc.] *[It is necessary to send the executed AMD to the custodian, but it is optional to mention this here]*

Signature of the executor

[Full signature or Thumb impression]

Full name:

Date:

Place:

Signature of witnesses

I, as a witness, record my satisfaction that the document has been executed voluntarily and without any coercion, duress, inducement, or compulsion.

Witness 1	**Signature**
Name: Address: Government ID: Email ID: Mobile No.:	

I, as a witness, record my satisfaction that the document has been executed voluntarily and without any coercion, duress, inducement, or compulsion.

Witness 2	**Signature**
Name: Address: Government ID: Email ID: Mobile No:	

Date:

Place:

Notarisation

This directive and authorisation of Healthcare Power of Attorneys has been signed in the presence of the undersigned by _____ (Declarant) and I record my satisfaction that the document has been executed voluntarily and without any coercion or inducement or compulsion.

SIGNED BEFORE ME

_____

(Full name of notary)

APPROPRIATE AUTHORITY, STAMP

Date:

Place: