Avera St. Luke's Hospital
305 South State Street
Aberdeen, SD 57401
(605) 622-5000

Living Will Declaration

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive.

Prepare this living will carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This living will remains valid and in effect until and unless you revoke it. Review this document periodically to make sure it continues to reflect your wishes. You may amend or revoke this living will at any time by notifying your physician and other healthcare providers. You should give copies of this living will to your family, your physician and your health care facility. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you and a notary public.

Terms used in this Living Will shall mean the following:

(1) "Attending physician," the physician who has primary responsibility for the treatment and care of the patient;

(2) "Declaration," a writing executed in accordance with the requirements of South Dakota Codified Law § 34-12D-2;

(3) "Health care provider," any licensed health care facility or any person, corporation, or organization licensed, certified or otherwise authorized or permitted by law to administer health care;

(4) "Life-sustaining treatment," any medical procedure or intervention that, when administered to a patient, will serve only to postpone the moment of death or to maintain the patient in a condition of permanent unconsciousness. The term does not include the provision of appropriate care to maintain comfort, hygiene and human dignity, the oral administration of food and water, tor the administration of any medication or other medical procedure deemed necessary to alleviate pain;

(5) "Person," an individual, corporation, business trust, estate, trust, limited liability company, partnership, association, joint venture, government, governmental subdivision, or agency, or any other legal or commercial entity;

(6) "Physician," an individual licensed to practice medicine in this state;

(7) "Terminal condition," an incurable and irreversible condition such that, in accordance with accepted medical standards, death is imminent if life-sustaining treatment is not

administered, or a coma or other condition of permanent unconsciousness that, in accordance with accepted medical standards will last indefinitely without significant improvement and in which the individual is unable to communicate verbally or nonverbally, demonstrates no purposeful movement or motor ability, and is unable to interact purposefully with environmental stimulation.

TO MY FAMILY, HEALTH CARE PROVIDER AND ALL THOSE CONCERNED WITH MY CARE:

I, ____, hereby appoint:
(Name) (Date of Birth)

direct you to follow my wishes for care if I am in a terminal condition, my death is imminent and I am unable to communicate my decisions about my medical care.

With respect to any life-sustaining treatment, I direct the following:
(**Initial only one of the following options.** If you do not agree with either of the following options, space is provided below for you to write your own instructions.)

___ If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life-sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

___ Even if my death is imminent or I am permanently unconscious, I choose to prolong my life.

___ I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent or I am permanently unconscious:

____
____
____
____

Artificial Nutrition and Hydration: food and water provided by means of a tube inserted into the stomach or intestine or needle into a vein

With respect to artificial nutrition and hydration, I direct the following:
(Initial only one)

___ If my death is imminent or I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

___ Even if my death is imminent or I am permanently unconscious, I want artificial nutrition and hydration.

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Living Will Declaration

Date ______________ ____________________________________
(Your Signature)

______________________ ____________________________________
(Your Address) (type or print your signature)

The declarant voluntarily signed this document in my presence.

___________________________ ________________________________
Witness Witness

___________________________ ________________________________
Address Address

On this the ________ day of ________________________, ______, the declarant, _____________, personally appeared before the undersigned officer and signed the foregoing instrument in my presence.
Dated this _____ day of _____________________, ______.

______________________________________, Notary Public

My commission expires: _____________________