

**MONTANA MENTAL HEALTH NURSING CARE CENTER  
ADVANCE MEDICAL DIRECTIVE**

\_\_\_\_\_  
(PRINT YOUR FULL NAME)

\_\_\_\_\_  
(DATE OF BIRTH)

\_\_\_\_\_  
(SOCIAL SECURITY NUMBER)

**Instructions for Healthcare (Living Will)**

*If you fill out this part of the form, you may strike any wording you do not want.*

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 become valid **only when BOTH** of the following two conditions exist:

1. **I have a terminal condition;  
AND**
2. **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.**

**General Treatment Directions** (Check the boxes that express your wishes).

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any healthcare treatment. I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

I provide no directions at this time.

**Choice To Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards;

**OR**

**Choice Not to Prolong Life:** I do not want my life to be prolonged if (1) I have an incurable or irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, 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 may be given **to maintain my dignity, keep me comfortable, and relieve pain even if it hastens my death.**

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

**If I cannot eat, I do not want a tube** inserted in my nose, 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.

† If my **heart stops** beating or I **stop** breathing, I **do not want cardiopulmonary resuscitation (CPR)**.

† If I cannot breathe on my own, I **do not want to be placed on a ventilator** (breathing machine).

† Additional directions regarding medication and treatment. (List any directions here):

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**Your signature** (Ask two people to watch you sign and have them sign below)

1. I revoke any prior healthcare advance directive or direction.
2. This document can be revoked at any time.

I sign this document on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(DAY) (MONTH) (YEAR)

\_\_\_\_\_  
(SIGNATURE) (PRINT FULL NAME)

\_\_\_\_\_  
(ADDRESS) (CITY) (STATE) (ZIP CODE)

\_\_\_\_\_  
(HOME PHONE NUMBER) (WORK PHONE NUMBER)

**Witness Signatures:**

First Witness:

\_\_\_\_\_  
(SIGNATURE) (PRINT FULL NAME)

\_\_\_\_\_  
(ADDRESS) (CITY) (STATE) (ZIP CODE)

Second Witness:

\_\_\_\_\_  
(SIGNATURE) (PRINT FULL NAME)

\_\_\_\_\_  
(ADDRESS) (CITY) (STATE) (ZIP CODE)