Consent to Withholding or Withdrawing of Life-Prolonging Treatment or Measures CP2.13

1. **Patient’s Condition.** I (we) have consulted with Dr. _________________________ concerning the condition of _______________________________ and the alternative medical responses to the condition. I (we) have been informed by Dr. _________________________ that the patient is suffering from a

- [ ] terminal condition
- [ ] persistent vegetative state
- [ ] end-stage condition

and that there is no reasonable medical probability that the patient will recover his / her capacity (ability) to make his / her own decision about life-prolonging procedures. I (we) understand that two physicians have made these findings, and I (we) are satisfied with these findings.

2. **I (we) understand that in making decisions about life-prolonging procedures for ________________________________ I (we) are required by law to make only those decisions for the patient that I (we) believe he / she would have made for himself / herself under these circumstances, if he / she was able to. If I (we) do not have any indication of what the patient's decision would have been, I (we) understand that then the law requires me (us) to act in the patient's best interest.

3. **I (we) agree to the withholding or withdrawing of life-prolonging procedures from the patient to permit the natural dying process.** I (we) understand that this means that mechanical and other artificial life-prolonging procedures will not be started, and will be withdrawn if already started, unless I (we) specifically request otherwise below:

   _______________________________________________________________________

   Signature ___________________________ Date __________ Relationship to Patient ___________________________

   Signature ___________________________ Date __________ Relationship to Patient ___________________________

   Signature ___________________________ Date __________ Relationship to Patient ___________________________

   We witnessed the consultation between the persons signing above concerning use of life-prolonging procedures. We also witnessed their signatures to this document.

   ___________________________ Date ________
   Witness______________________________

   ___________________________ Date ________
   Witness______________________________

Patient Name: ___________________________
Patient Identification #: ___________________________