

Living Will template (1 - with a representative).

DO NOT FILL THIS FORM IN; IT IS ONLY TO HELP YOU FILL IN THE SPANISH FORM.

THE ORIGINAL SPANISH VERSION MUST BE SIGNED BY YOURSELF ON EVERY PAGE.

This is a translation of the template provided by the Conselleria de Salut (Health Department), it is a model and may be adapted to your own personal needs. Your living will must be in Spanish for it to be applicable, so we have added numbers to the original and this translation to make it easier for you to do so. You can remove any points that you do not agree with, if you wish to add or adapt any points, you must ensure that the translation into Spanish is correct, we can help you with this if you wish.

If you have any questions relating to this please do not hesitate to contact us. A euthanasia clause has been added in section V, this can be left as it is, adapted or totally removed depending on your wishes in this matter. For this living will to be fully enforced it is strongly advisable to have it registered see document HOW TO REGISTER A LIVING WILL.

ORIGINAL TEXT BEGINS HERE, any writing in Italics are our comments.

Before filling in this document you must ask for medical help and guidance to understand the scope of your decisions. Sections I, II and III follow on and complement each other, as without the information specified in these first sections, the instructions in section III have no purpose.

PERSONAL DATA

Name:

Gender:

Marital status:

DNI/NIE/Passport number:

Health card number: *(the number under your name with lots of Bs)*

CIP number: *(you can find this on your health card, it will start with 38)*

Place of birth:

Date of birth:

Nationality:

Address:

Telephone number:

With full ability to make free decisions based on plentiful information that has allowed me to reflect, I express my Living Will, that contains MY PRESENT WISHES (in accord with Law 1/2006, of the 3rd of March on Living Wills) that I want to be respected during my health care when I am in a situation where, due to my physical or mental condition, I can no longer express my own wishes:

I Criteria that I want to be considered.

I consider quality of life to be very important, I relate said quality of life to certain circumstances, as an example:

1. Being able to communicate by any means and the ability to connect with others
1. Not suffering considerable pain, whether physical or mental.
2. Being able to maintain functional independence, enough to allow me to be self sufficient in my day to day activities.
3. The preference to not prolong life when in irreversible clinical situations.
4. The preference to die at home/hospital (*choose one*) the last days of my life.
5. In case of any questions when interpreting this document, please consider the opinion of my representative.
6. If I am in a momentary state of lucidity I do/do not (*choose one*) wish to be informed of my diagnosis.

II Clinical situations I want to be considered in this document.

I want the principles mentioned in the previous section to be respected in the following situations as well as others that may arise:

1. Irreversible illness that will inevitably and quickly lead to my death.
2. Chronic vegetative state.
3. Advanced stage of illness with a terminal diagnosis.
4. Serious dementia.
5. Advanced incurable disease (progressive, gradual illness affecting autonomy and quality of life in varying degrees, with a varying response to specific treatments that will lead to death in the medium term).
6. Terminal illness (advanced illness, evolving and irreversible, with multiple symptoms, emotional impact, loss of autonomy, with little or no possibility of responding to specific treatments, with a prognosis of less than six months and progressive fragility).
7. Agony (that precedes death when this takes place gradually, involving a serious physical deterioration, as well as extreme weakness, high incidence of cognitive impairment and loss of conscience, difficulty relating to others and ingesting food, with a prognosis of days or hours).

III. Instructions regarding health care

What has been explained above, in accord with specific health care situations and criteria, implies making decisions such as the following:

1. I want to end my life without life support machines, assisted breathing or any other disproportionate and futile extraordinary measure that is only aimed at artificially

prolonging my survival, and that these measures be removed if they have already been put in place.

2. That I am provided with the medication needed to alleviate as much as possible any discomfort, mental suffering or physical pain that my illness may cause me.
3. That notwithstanding the decision I make, I am guaranteed the assistance needed to ensure a dignified death.
4. I refuse any complementary medication or treatment or to be submitted to tests and diagnostic procedures, if these are to improve my recovery or mitigate my symptoms.
5. If I were pregnant and any of the situations described in section II were to occur, I want this document to be suspended until the birth as long as this does not affect the fetus negatively.
6. I wish for my loved ones and relatives to be with me in the last moments of my life, if they so wish and within the context of the care possibilities.

IV. Instructions regarding my body

1. I want to donate my organs so they can be transplanted to another person who needs them.
2. I want to donate my organs for research.
3. I want to donate my body for research including an autopsy, if needed, according to medical criteria.
4. I want to donate my organs for medical teaching purposes.
5. I want to donate my tissue for clinical use.
6. I want to donate my tissue for research.
7. I want to be cremated
8. I want to be buried
9. Religious ceremony
10. Catholiic ceremony
11. Other religions.

V. Other instructions that within this context are not contrary to this regulation.

1. I want my life to be ended by euthanasia.
2. I consider constant and unbearable physical or mental suffering to be incompatible with my personal dignity and that some chronic serious ailments, such as neurodegenerative illnesses (dementia, alzheimer, etc) will cause a deterioration of my personality and mental faculties, leading me to be unaware of my illness and values.

Therefore, even though I cannot express it, remember it, or in the view of other persons, do not show external signs of suffering, at the moment that I am no longer able to fend for myself, or do not recognise my family and friends, or find myself in a clinical situation of a moderate dementia (GDS- FAST 5, according to the Reisberg Scale), I want my will to be respected and my life to be ended by euthanasia.

3. During the time needed to process my request for euthanasia, or in the case this were refused, I refuse any kind of life support, treatment, intervention or procedure that contributes to keeping me alive (antibiotics, nutrition-hydration with fluids, nasogastric tube or gastrostomy, pacemaker or defibrillator, etc). I request that my suffering be alleviated with any measures available, and if I am in an advanced or terminal state, I want to die while in a deep palliative sedation, maintained until the moment of my death.

If there are any doubts regarding the irreversibility of my situation of incapacity to decide, I want to make clear that this will not change my firm decision to not support a life that depends on others for day to day activities.

4. If any member of the professional care team declares a conscientious objection to any of my instructions, I request that they be replaced by another member, guaranteeing my right to freely decide about my life and death.

VI Designation of a representative

In accordance with article 5 of Law 1/2006, of the 3rd of March, Relating to Living Wills, I appoint a representative to act as a valid and needed spokesperson for me with the doctor, or the medical team that will assist me, if I find myself unable to express my will, as well as if there is any doubt when interpreting my life plan or my values relating to quality of life, and I want their opinion to be considered. Therefore I designate (*name and surname*) with DNI/NIE/Passport number and address in (*street*), (*number*), (*town*) and (*telephone*).

As a consequence I authorise my representative to make decisions regarding my health if I am unable to do so.

- As long as they do not go against my will that is expressed in this document.
- Specific limitations:(*set any limitations you feel are necessary*)

Date

Signature

In the case of death or resignation of my representative spokesperson a designate a substitute:

Name and surname:

Address:

Telephone:

Date:

Signature

VIII. Representatives acceptance

I accept the appointment and I am agreeable to being the representative of (*your name and surname*) if they cannot express their will regarding their health care. I understand and agree to follow the guidelines expressed in this document by the person I represent. I understand that my representation is only valid if the person I represent is not able to express these

guidelines themselves and as long as they have not revoked them in full or in the part pertaining to me in this document.

Name and surname of the representative:

DNI/NIF/PASSPORT:

Date:

Signature of the representative