68/317 Soi Moo Baan Hua Na, Nongkae Hua Hin, Prachaupkhirikhan, 77110
โทร. 02-1116644
E-mail: info@bewell.co.th

LIVING WILL
BE WELL MEDICAL CENTER

Date: .....

Name ..... DOB ..... Age .....

Identification number/ Passport Number: .....

Address .....

.....

Contact .....

I, being of sound mind, **willfully and voluntarily** state my wish that my Attending physician, medical practitioners, healhtcare providers in any healthcare centers who are responsible for my health respect my decision in this living will appropriately.

Should I suffer any of the following conditions (those items checked with my signature) which indicate the terminal phase of illness or injury – I do not wish to remain in such a condition,

Permanent unconscious condition: Condition caused by illness or injury and I become totally unaware of people or surroundings, I do not recognize loved one, unable to make decisions, with little chance of ever waking up from the unconscious condition (coma).

End-stage illness: I have an illness that has reached its final stages in spite of full medical treatment – for example: widespread cancer that no longer responds to treatment; chronically diseased and/or damaged heart and lungs, where oxygen is required most of the time and physical activities are limited due to a feeling of suffocation.

Fully dependent on life support: I am no longer able to breath on my own, continuous use of a breathing machine, IV fluids or other medications or equipment that help the lungs, heart, kidneys and other vital organs to continue to function but will not cure the underlying

condition.

If I am in conditions as mentioned in page 1 or my conditions are untreatable and all treatments would only serve either to delay the moment of my death or to prolong suffering.

I wish to be medically treated as follows (checking **"Yes"** with my signature means that I want the treatment; checking **"No"** with my signature means that I do not want the treatment)

1. **Cardiopulmonary resuscitation (CPR).** To cause the heartbeat to restart and to restore breathing after it has stopped. Usually this involves electric shock, chest compressions and breathing assistance.	Yes ..... No .....
2. **Life support or other artificial medical support.** Continuous use of a breathing machine (Mechanical Ventilator), other medications or equipments that help the lungs, heart to continue to function but not to cure the primary illness.	Yes ..... No .....
3. **Feeding tubes.** Use of tubes to deliver food and water to the stomach, artificially delivered nutrition and hydration to my body.	Yes ..... No .....
4. **Pain Management.** Use of pain medications of any form (Intravenous, Oral, transdermal patch) to relieve pain and suffering. (Example: Morphine intravenously for severe pain management). Intravenous fluids as a route of pain medication delivery.	Yes ..... No .....
5. **Treatment of new complications.** Use of surgery, blood transfusions or antibiotics or other treatments that will deal with a new condition but will not relieve or cure the primary illness	Yes ..... No .....
6. **Other medical treatment:** This included any medications or procedures such as antibiotic, chemotherapy, surgical procedure which will not cure my underlying condition but prolong my suffering.	Yes ..... No .....

Where some medical treatments or procedures have been provided by any health professionals at any healthcare centers without their knowing the contents of my living will or my wishes, I call upon such professionals to withdraw medical treatment and the procedures mentioned above.

All physicians, nurses, other healthcare providers who have executed my intention as stated in this Living Will are deemed not legally responsible and released from all liabilities. I read and understood the conditions and regulations of the Living Will as attached herein.

I sign this document voluntarily, and I make it upon witness. I also make a copy to be held by my proxy, (Bewell Medical Center) and witness in order that they may inform medical professionals and health care staff about the living will when I am admitted (to any healthcare facility).

PATIENT DECLARATION

I, _____ hereby certify that I am competent and copy to be held by my proxy, (Bewell Medical Center) and witness in order that they may inform medical professionals and health care staff about the living will when I am admitted (to any healthcare facility).

Signature of Declarant _____ Date: _____

DECLARATION BY PHYSICIAN

I, Dr _____, License: _____,do hereby certify that the patient, _____, is fully conscious while completing this Living Will

Signature of Declarant _____ Date: _____

NOTARY PUBLIC

Signature _____

(Kantee Isareenuruk)

License Number: _____

WITNESS

Signature _____ Date _____

Name _____ Relationship _____

Address _____

_____

_____