Name: .....

Birth Date:..... Age:..... Gender:.....

Nationality.....

HN: ..... EN/AN:.....

Visit Date:..... OPD/Ward.....

Physician:.....

Allergies:.....

Living Will

Location .....

Date .....

I, (First name .....Middle name.....Last Name.....

Passport Number .....Nationality.....

Address in Thailand .....

Address in home country.....

Tel no.....Office telephone no.....

E – mail address.....

1. being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. I wish to utilize my right according to Thai Statue No. 12 of the National Health Law of the year 2550. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

2. I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness. I wish that the treatment be stopped by signing the terms below.

I do not want	signature
cardiac resuscitation	
Tracheostomy	
mechanical respiration	
Feeding tube	
Other (specify)	

3. Even though I have directed that I refuse treatment as shown in #2 above, I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

I wish that the medical team carry out my wishes as follows:

☐ I wish to expire at home

☐ I wish to receive spiritual support as follows.....

I want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

(First & Last Name).....

The declaring or the person on behalf of and at the direction of the declaring knowingly and voluntarily signed this writing by signature or mark in my presence.

Name: .....

Birth Date:..... Age:..... Gender:.....

Nationality.....

HN: ..... EN/AN:.....

Visit Date:..... OPD/Ward.....

Physician:.....

Allergies:.....

Living Will

I issued this directive at the presence of the witnesses as shown in the signatures below.

Signature .....

Declaring

Signature .....

Relative or Acquaintance

Signature ..... Signature.....

First & Last Name..... First & Last Name.....

Witness Witness

Relative or Acquaintance

First & Last Name .....Relationship.....

Passport or ID No. .....

Address .....

.....

Telephone No. ..... Office phone No. .....

Witness

First & Last Name .....Relationship.....

Passport or ID No. .....

Address .....

Telephone No. ..... Office phone No. .....

Witness

First & Last Name .....Relationship.....

Passport or ID No. .....

Address .....

Telephone No. ..... Office phone No. .....

Note:

This Declation is to help facilitate the wishes of the Declaring to refuse medical treatment according to Thai Statue No. 12 of the National Health Law of the year 2550. The Declaring can clarify the intent to suit his/her personal situations.