The Letter of Intent for the Choice of Hospice Palliative Care and Life-Sustaining Treatment (Reference Template)

If I_____(signature) am suffering from serious injury or illness, and diagnosed by a physician as incurable, and there is medical evidence showed that the prognosis is fatal within near future, I shall make the following choices according to rights conferred by Hospice and Palliative Care Act, Articles 4, 5 and Article 7, Paragraph 1, subparagraph 2: (please select ■)

☐**Accept** Hospice palliative care (Refers to the mitigatory and supportive medical care given to relieve terminal illness patients from and rid of physical , mental and spiritual pain, to improve their quality of life.)

☐**Accept** No cardiopulmonary resuscitation (CPR) (Refers to the implementation of the standard first aid procedures or other emergency treatments on terminally ill or dying patients, or patients without vital sign. It includes endotracheal intubation, chest compression, injection of resuscitation drugs, external defibrillation, artificial cardiac pacing, mouth-to-mouth ventilation and ventilator use, etc.)

☐**Accept** No life-sustaining treatment (Refers to the medical procedures which could maintain terminal illness patients' vital signs to extend dying process without curative effect.)

☐**Agree** Note above will mark in the national health insurance certificate (NHI card)

Signatory: (Signature) ID No:

Address: Phone No:

☐**Yes** ☐**No** An adult (If the signer is a minor, this letter of intent is deemed as Hospice Palliative Care Act, article 4 paragraph 1 is required, who may write a letter of intent for the choice of hospice palliative care or life-sustaining treatment.)

Date of Birth:_____(YYYY)_____(MM)_____(DD)

Witness 1: (Signature) ID No:

Address: Phone No:

Date of Birth:_____(YYYY)_____(MM)_____(DD)

Witness 2: (Signature) ID No:

Address: Phone No:

Date of Birth:_____(YYYY)_____(MM)_____(DD)

In accordance with the Hospice Palliative Care Act, article 4, terminal illness patients write a letter of intent must be witnessed by two or more persons with full disposing capacity. However, the staff of medical institution who implement HPC and the choice of LST for the decision maker may not serve as the witnesses.

Legal Representative: (If the signatory is a minor, it has to be filled.)

Signature: ID No:

Address: Phone No:

Date of Birth:_____(YYYY)_____(MM)_____(DD)

In accordance with the Hospice Palliative Care Act, article 7 paragraph 1 subparagraph 2, the letter of intent signed by a minor shall obtain the consent of his/her legal representative.

Medical Surrogate Agent: (The signatory is a medical surrogate agent, it has to be filled and the form of appointment medical surrogate agent shall be attached)

Signature: ID No :

Address: Phone No:

Date of Birth:_____(YYYY)_____(MM)_____(DD)

In accordance with the Hospice Palliative Care Act, article 5, the decision maker may designate a medical surrogate agent in advance, give details of the designation in writing. The agent may sign on his/her behalf expression of his/her will become impossible.

Date:_____(YYYY)_____(MM)_____(DD) (Required)