Advance Healthcare Directive

Name: _____
Alias (street name): _____
Birthday:_____

I (write name here) _____ understand that this form allows me to explain what I want for my health care if I cannot speak for myself. I can name a person to make health care decisions for me and give guidance about what I might want.

Note: **You do not have to complete all parts of this form**. You can stop filling out this form at any-time. If you need more room to share your wishes, feel free to **continue writing on the back of each page as needed**. This advance directive can be a work in progress and be changed at any time. To make this advance directive legal, you will need to sign it and have it witnessed by two people (Cannot be either health care surrogate or someone who will inherit from you).

1. Please share what quality of life means to you:

   _____

   _____

2. Please share what is important to you for your health or health care at the end of your life:

   _____

   _____

3. Please share any fears you might have about health or health care when you are seriously ill or dying:

   _____

   _____

4. Please share what you would want people to do to respect your dignity at the end of your life:

   _____

   _____

5. Please share if there would ever come a time when changes in your health would lead you to be at peace with dying. For example, if you could not move or respond independently.

   _____

   _____

6. Please share what are the things you are most proud of in your life.

_____

_____

7. As you reflect on your life, please share how you would want to be remembered.

_____

_____

Choosing a Healthcare Surrogate

A "Healthcare Surrogate" is the person you choose who would make health care decisions for you if you were unable to speak for yourself. Some qualities to consider when choosing a person to make health care decisions for you:

• Someone who knows you really well • Trustworthy	• Dependable • Good Communicator • Calm in an emergency

8. This is the person I want to make healthcare decisions for me:
   Name: _____
   Relationship to me: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone number (include area code): _____

9. This is another person I trust to make health care decisions for me (if the first person is not available):
   Name: _____
   Relationship to me: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone number (include area code): _____

10. Is there anything specific you want to share with this individual(s)?

_____

_____

_____

11. Please check the following treatments you would like medical professionals to use.

Treatment options I would like to have depending on condition:	If there is a good chance I would recover:	If others had to completely take care of me:	If I became permanently unconscious:	If I am dying:
a. CPR (trying to start my heart)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
b. Mechanical Ventilation (breathing tube)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
c. Feeding Tube (tube into belly to feed you)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
d. Blood Transfusions (you need someone else's blood to stay alive)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
e. Dialysis (kidneys don't work and machine is needed to filter toxins from your body)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
f. Antibiotics (medicines to treat infection)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
I will let my health care surrogate decide any items (above) that were left blank. ☐No ☐Yes				

12. My favorite hospital where I would like to receive care is: _____

13. My doctor's name is: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone number (include area code): _____

14. I have talked to my doctor about my wishes: ☐ No ☐ Yes

15. If possible, I would prefer to die: ☐ in a hospital ☐ at home ☐ in temporary housing

16. If I need pain medication when I am seriously ill or dying (check one):

☐ I want pain medication even if it makes me less alert.
☐ I would rather be in pain than risk being less alert.
☐ I would let my health care surrogate decide.
☐ Other, please specify:_____

17. These are my wishes about organ donation (organs include: heart, kidney, lungs, skin, eyes, etc.) (Check one.)

☐ I want to donate all my organs
☐ I only wish to donate the following organs:_____
_____

The organs I donate can be used for the following purposes:
☐ Transplant to help another person
☐ Other: _____

☐ I do not want to donate my organs.
☐ I will let my health care surrogate decide.

18. These are my wishes about what happens to my body after I die (check one):

☐ I want to be buried — At the following location:
_____
_____

☐ I want to be cremated. — ☐ Ashes stored ☐ Ashes spread
If spread, at the following location:
_____
_____

☐ I will let my health care surrogate decide

Other wishes for what happens to my body after I die:
_____
_____

19. I want a memorial service: ☐ No ☐ Yes

If you indicated yes, please share any specific instructions for the service:

_____
_____
_____
_____

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

To make this document legal: Sign and Date Below and Have Two People Witness.

My signature: _____

Date Signed: _____

If I cannot sign my name, I can ask someone to sign this document for me.
Signature of the person who I asked to sign this document for me:

_____

Printed name of the person who I asked to sign this document for me:

_____

Phone number: _____

Signature of Two Witnesses (Cannot be either health care surrogate or someone who will inherit from you)
Signature: _____ Date: _____ Print: _____

Signature: _____ Date: _____ Print: _____

I would like copies of this form for/sent to:

1. _____
2. _____
3. _____
4. _____
5. _____