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HEALTH CARE DIRECTIVE QUESTIONNAIRE

1. Please list, in order, the person(s) you nominate to make health care decisions on your behalf if you are unable to do so yourself. Please include name, address, and phone number:

Name: _____
Address: _____
Phone: _____ Email: _____

Name: _____
Address: _____
Phone: _____ Email: _____

Name: _____
Address: _____
Phone: _____ Email: _____

Name: _____
Address: _____
Phone: _____ Email: _____

Check here [ ] and use back of form if more persons are nominated

2. My health care agent's authority shall take effect on (mark one)
___ When my primary physician determines that I am unable to make my own health care decisions; or
___ immediately.

(a) If immediately, when, if at all will the power expire? _____

3. Do you give your health care agent the authority to donate any of your body parts or organs?
___ Yes
___ No

(a) If yes, state any limitations of body parts or organs that may be donated: _____
_____
_____

(b) If yes, state any purposes (e.g., transplant, therapy, research, education, etc.) for which your body parts or organs may be donated: _____
_____
_____

(c) If yes, state any purposes (e.g., transplant, therapy, research, education, etc.) for which your body parts or organs may NOT be donated: _____
_____

4. Do you give your health care agent the authority to direct the disposition of your remains?
___ Yes
___ No

(a) If yes, state any wishes you have regarding (i) burial or cremation and (ii) where you want to be buried or what you want done with your ashes:

_____
_____
_____

5. Do you give your health care agent the authority to authorize an autopsy?
___ Yes
___ No

6. Please list, in order, the person(s) you nominate to serve as conservator for your person if you are unable to care for yourself. Please include name, address, and phone number:

Name:_____
Address:_____
Phone: _____ Email:_____

Name:_____
Address:_____
Phone: _____ Email:_____

Name:_____
Address:_____
Phone: _____ Email:_____

Name:_____
Address:_____
Phone: _____ Email:_____

Check here [ ] and use back of form if more persons are nominated

7. Do you give your health care agent the power to arrange for your funeral or other memorial services?
___ Yes
___ No

8. Please mark ONE of the following statements concerning life-prolonging treatment, services, procedures, and end-of-life decisions:

___ I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life and my death is likely to occur within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period. Thus, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued (1) if I am in an irreversible coma or persistent vegetative state; (2) if I am terminally ill and the use of life-sustaining

procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of treatment outweigh the expected benefits. By an "irreversible coma," I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3), above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life.

OR

___ If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) "terminal condition" shall mean an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures serves only to postpone the moment of my death; and (2) "life-sustaining procedures" shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function that will serve only to artificially prolong the moment of my death. The term "life-sustaining procedures" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

OR

___ I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma," I mean a coma from which the treating physician or physicians have reasonably concluded I will never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life.

OR

___ I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted heath care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

OR

___ If you have other wishes not described above, please state them here: _____
_____
_____
_____
_____
_____

9. Each of the following provisions is optional. Please indicate whether you want this language included in your advance health care directive:

PALLIATIVE CARE. I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. I wish to receive any other forms of palliative care that may ease my suffering.
___ Yes
___ No

INDEPENDENT LIVING. I wish to live in my home for as long as that is reasonably possible without endangering my physical or mental health and safety and to receive whatever assistance from household employees or personal care givers may be necessary to permit me to do so. I wish to return home as soon as reasonably possible after any hospitalization or transfer to convalescent care. If my agent determines that I am no longer able to live in my home, I wish that my agent consider alternatives to convalescent care which will permit me as much privacy and autonomy as possible, including such options as placing me in an assisted living facility or board and care facility.

___ Yes
___ No

SOCIAL INTERACTION. I wish to be encouraged to maintain my social relationships and to engage in social interaction even if I am no longer able to recognize my family and friends or to fully participate in social activities.

___ Yes
___ No

RELIGIOUS OR SPIRITUAL ACTIVITY. My involvement with _____ [name of your church, synagogue, or other religious or spiritual institution] has been very important to me. I wish to maintain that involvement as long as possible, even if I no longer fully appreciate its significance. To that end, and in accordance with my established beliefs and customary activities, my agent shall provide for the presence and involvement of church persons, clergy or other persons to attend to my spiritual needs and permit them access to me and shall arrange for my access to activities and publications, including books, tapes, and similar materials, associated with my spiritual involvement.

___ Yes
___ No

OUTDOOR ACTIVITIES. I wish to spend significant time outdoors. If I can no longer travel, I wish my agent to arrange for trips to local parks and other areas where I may be outdoors in a natural setting.

___ Yes
___ No

10. If you want to designate a primary physician, please list his/her name, address, and phone number:

_____

11. If you want to designate a secondary physician, please list his/her name, address, and phone number:

_____