

Health Care Directive Survey Form

A health care directive allows you to select one or more primary and alternate agents to make health care decisions for you if you are unable to speak for yourself. Taking the time to prepare a health care directive avoids having the Court appoint a guardian for you if you are unable to make health care decisions for yourself.

Personal Data

Name _____ Date of Birth _____
(First Middle & Last)

U.S. Citizen? Yes _____ No _____

Spouse Name _____ Date of Birth _____
(First Middle & Last)

U.S. Citizen? Yes _____ No _____

Street Address _____ Apt _____ County _____

City _____ State _____ Zip _____

Telephone Number: H: _____ Cell: _____ Spouse Cell: _____

Work: _____ Spouse Work: _____ Email: _____

Agents Authority to Act

You may choose co-health care agents or co-successor health care agents if you wish. If you choose more than one health care agent please select one these two choices.

_____ Co-agents may act independently of one another.

_____ Co-agents may not act independently and must be in complete agreement before implementing a health care decision on my behalf.

Health Care Agent(s)

Name: _____

Address: _____

Phone(s): _____ (c); _____ (h)

Name: _____

Address: _____

Phone(s): _____ (c); _____ (h)

Alternate Health Care Agent(s)

Name: _____

Address: _____

Phone(s): _____ (c); _____ (h)

Name: _____

Address: _____

Phone(s): _____ (c); _____ (h)

Directives

Please carefully consider each of the scenarios below and select the choice that best suits your beliefs and values. Your answers to Questions 1 through 4 below only apply when your doctor informs you or your health care agent that nothing more can be done to improve your health or save your life.

1. If I am diagnosed as having an incurable and irreversible illness, disease, or condition and if my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal:

_____ I direct that life-sustaining treatment which would serve only to artificially prolong my dying be withheld or ended. I also direct that I be given all medically appropriate treatment and care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

2. If there should come a time when I become permanently unconscious and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my ability to interact with other people and my surroundings:

_____ I direct that life-sustaining treatment be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate treatment and care necessary to provide for my personal hygiene and dignity.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

3. If there comes a time when I am diagnosed as having an incurable and irreversible illness, disease or condition which may not be terminal, but causes me to experience severe and worsening physical or mental deterioration, and I will never regain the ability to make decisions and express my wishes:

_____ I direct that life-sustaining measures be withheld or discontinued and that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

4. If I am in the condition(s) described above, I feel especially strongly about the following forms of treatment:

(Initial all those that apply)

_____ I do not want cardiopulmonary resuscitation (CPR)

_____ I do not want mechanical respiration.

_____ I do not want tube feeding

_____ I do not want tube hydration

_____ I do not want antibiotics

_____ I **do** want maximum pain relief, even if it may hasten my death.

Organ Donation/Cremation Instructions

_____ I **do not** want to be an organ donor.

_____ I **do** want to be an organ donor.

_____ I **do not** want to be cremated.

_____ I **do** want to be cremated.

Other Health Care Instructions
