Care Directive Questionnaire

A Care Directive is a written document regarding lifestyle choices, end-of-life care and burial preferences. Having a Care Directive provides you some assurance that your wishes will be honored if you can no longer express them. Completion of this form is purely optional.

Name: ____

Part I: My Living Will

Statement of Philosophy: I enjoy and value my life. I do not want my life to end, but I also recognize and accept the fact of my own mortality. I do not seek to die, but I do not want my life to be prolonged or my death to be postponed in all circumstances. Accordingly, I have prepared this document to express my wishes regarding my medical treatment.

Section A

These are my wishes if I have a terminal condition (Defined as an ongoing condition caused by illness or injury that has no cure and from which doctors expect that I will pass away within six (6) months, even with medical treatment. Life-sustaining treatments will only prolong the dying process.):

Life-sustaining treatments (initial one):

________ I do not want cardiopulmonary resuscitation (CPR) or life-support (including respirators or ventilators). If life-sustaining treatments are started, I want them stopped.

________ I want the life-sustaining treatments that my doctors think are best for me.

________ Other: ____

Artificial Nutrition and Hydration (initial one):

________ I do not want artificial nutrition (tube feeding) or hydration started if they would be the primary treatments keeping me alive. If artificial nutrition and hydration are started and they become the primary treatments keeping me alive, then I want them stopped.

________ I want artificial nutrition and hydration even if they are the primary treatments keeping me alive.

________ Other: ____

Comfort Care (initial one):

________ I want to be kept as comfortable and pain free as possible, even if such care prolongs my dying or shortens my life. This includes palliative care.

________ Other: ____

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Section B

These are my wishes if I am in a persistent vegetative state/coma (meaning that I am unconscious for at least ten (10) days, without any reasonable hope of regaining consciousness, even with medical treatment):

Life-sustaining treatments (initial one):

________ I do not want cardiopulmonary resuscitation (CPR) or life-support (including respirators or ventilators). If life-sustaining treatments are started, I want them stopped.

________ I want the life-sustaining treatments that my doctors think are best for me.

________ Other: ____

Artificial Nutrition and Hydration (initial one):

________ I do not want artificial nutrition (tube feeding) or hydration started if they would be the primary treatments keeping me alive. If artificial nutrition and hydration are started and they become the primary treatments keeping me alive, then I want them stopped.

________ I want artificial nutrition and hydration even if they are the primary treatments keeping me alive.

________ Other: ____

Comfort Care (initial one):

________ I want to be kept as comfortable and pain free as possible, even if such care prolongs my dying or shortens my life. This includes palliative care.

________ Other: ____

Part II: Organ Donation (initial all that apply)

________ I do not wish to make an organ or tissue donation.

________ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution.

Name of individual/institution: ____

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Upon my death, I wish to donate:

________ Any needed organ, tissue, or parts

________ The following parts or organs: ______________________________

To be used for (initial one):

________ Any legally authorized purpose

________ Transplant or therapeutic purposes only

________ Medical research

Part III: Funeral and Burial Preferences (initial all that apply)

My preference for a funeral service is:

________ No service

________ Traditional (includes visitation and a funeral service)

________ Open Casket ________ Closed Casket

________ Memorial (includes one or more services without the presence of the deceased)

________ Graveside (includes one service held at the graveside prior to internment)

________ I wish to be buried. My cemetery of choice is (include name and location):

____

____

________ I wish to be cremated. Preference for disposition of ashes:

________ Burial at cemetery ________ Scattering at cemetery

________ Deliver to survivors ________ Other: ______________________________

Part IV: Autopsy (initial one)

________ I do not wish for an autopsy to be performed.

________ I agree to an autopsy if my doctors recommend it.

________ Other: ______________________________

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Part V: Comfort Wishes (initial all that apply)

________ I wish to have personal care items such as nail clipping, hair brushing, haircuts, shaving, and oral hygiene conducted on a regular basis so long as they do not cause me pain or discomfort.

________ I would like to be taken outside on a daily basis, weather permitting.

________ I would like to visit my family so long as I am presentable, I add to the event and I am not overly burdensome to family members.

________ If my health permits, I enjoy the following hobbies:

____

____

________ If my health permits, I enjoy going to the following locations:

________ Mall ________ Museums ________ Beach ________ Parks

________ Movies ________ Restaurants ________ Theatrical plays

________ I enjoy reading books by the following authors or on the following subjects:

____

____

________ I enjoy watching the following on television:

____

____

Part VI: Food Preferences (initial all that apply)

________ I enjoy most foods and I am not a picky eater.

________ I prefer not to eat the following items:

____

____

________ I am allergic to the following items:

____

____

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Part VII: Religious Preferences (initial all that apply)

________ No religious preference

________ My religious preference is: ____

________ I would like to attend church services, if offered.

________ Other: ____

____

I understand that this Care Directive is meant to supplement my Durable Power of Attorney – Health Care and provide additional guidance to my Medical Patient Advocate. My wishes for care are expressed herein, but I understand that if these selections conflict with my Durable Power of Attorney – Health Care, my Power of Attorney document shall control. I understand and acknowledge that my Medical Patient Advocate has full decision making capabilities upon my incapacity/incompetency.

____

Print Name: ____

Witness Signature: ____

Witness Print Name: _______________________________________

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