

Quality of Life Directive

My Health Care Goals

Not Important

Very Important

Read each statement below and on a scale of "0" to "4," rate how important each of the health care goals are to you. In this case, "4" means "Extremely Important" and "0" means "Not Important at all." Remember reasonable medical care should always include maintaining a person's comfort, hygiene, and human dignity.

How Important is Pain Control?

- | | | | | | |
|---|---|---|---|---|---|
| • Being as comfortable and free from pain as possible. | 0 | 1 | 2 | 3 | 4 |
| • Having pain controlled, even if my ability to think clearly is reduced. | 0 | 1 | 2 | 3 | 4 |
| • Having pain controlled, even if it shortens my life. | 0 | 1 | 2 | 3 | 4 |

How Important Is the Use of Life Prolonging Treatment When:

- | | | | | | |
|--|---|---|---|---|---|
| • I have a reasonable chance (better than 50%) of recovering both physically and mentally. | 0 | 1 | 2 | 3 | 4 |
| • I have some physical limitations but can socially relate to those I care about. | 0 | 1 | 2 | 3 | 4 |
| • I can live a longer life no matter what my physical or mental health. | 0 | 1 | 2 | 3 | 4 |
| • I have little or no chance of doing everyday activities I enjoy. | 0 | 1 | 2 | 3 | 4 |
| • I am not able to socially relate to those I care about. | 0 | 1 | 2 | 3 | 4 |
| • I have severe and permanent brain injury and little chance of regaining consciousness. | 0 | 1 | 2 | 3 | 4 |
| • I have severe dementia or confusion and my condition will only get worse. | 0 | 1 | 2 | 3 | 4 |

Importance of Finances and Health Care:

- | | | | | | |
|--|---|---|---|---|---|
| • Having my wishes followed regardless of whether or not my finances are exhausted. | 0 | 1 | 2 | 3 | 4 |
| • Not being a financial burden to those around me. | 0 | 1 | 2 | 3 | 4 |
| • Not having my health care costs affect the financial situations of those I care about. | 0 | 1 | 2 | 3 | 4 |

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious or spiritual beliefs should affect my health care: _____

My religion/spirituality is: _____
 My congregation/spiritual community (name, city, state): _____

I wish to have my priest/pastor/rabbi/shaman/spiritual leader consulted. Yes No
 If yes, the person to be contacted is: _____

My Medical Treatment Preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you given your current as well as future health conditions.

Medical Procedure:

Ventilator/Respirator (A breathing machine)

Application: When you are unable to breathe on your own. A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure.

Sustained Condition: You cannot talk or eat by mouth on this machine.

My Feelings About This Procedure:

Medical Procedure: Nutrition support and hydration

Application: When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely.

Sustained Condition: Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.

My Feelings About This Procedure:

Medical Procedure: Cardiopulmonary Resuscitation (CPR)

Application: Actions to make your heart and lungs start if they stop, including pounding on your chest, electric shocks, medications, and a tube in your throat. A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.

My Feelings About This Procedure:

Medical Procedure: Dialysis

Application: A mechanical means of cleaning the blood when kidneys are not working.

My Feelings About This Procedure:

My Medical Treatment Preferences

My feelings or concerns about other medical treatments include:

If I am pregnant, my feelings about medical treatment would include:

Feelings About Quality and Length of Life

I have the following feelings about whether life should be preserved as long as possible:

The following kinds of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive:

My Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

At home _____

At a hospital. Which one? _____

At a nursing home. Which one? _____

Through hospice services/care. Which one? _____

From other health care providers. Which ones? _____

Other wishes I have about my care if I am dying: _____

Additional Health Care

My decision makers should also know these things about me to help them make decisions about my health care: _____

My Wishes About Donating Organs, Tissues, or Other Body Parts

Initial the lines that apply to you:

_____ I DO wish to donate organs, tissue, or other body parts when I die.

_____ Any needed organs, tissue, or other body parts

_____ Only the following listed organs, tissue, or body parts:

Limitations or special wishes I have include: _____

_____ I DO NOT wish to donate organs, tissue, or other body parts when I die.

Signature

I agree that these are my health care instructions and have completed this willingly. This worksheet is an attachment to my Health Care Directive.

Name (Print): _____

Signature: _____ Date completed: _____

Notary

State of _____ County of _____

This document was signed or acknowledged before me this _____
(day)

of _____, _____ by the above named principal.
(month) (year)

Signature of Notary Public

(Seal)

This form is not a statutory document. Its effect in your state should be discussed with a qualified attorney.