HEALTH CARE DIRECTIVE (LIVING WILL)

I, _____ want everyone who cares for me to know what health care I want, when I cannot let others know what I want.

SECTION 1:

I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

A quality of life that is unacceptable to me means (check all that apply):

- ☐ Unconscious (chronic coma or persistent vegetative state)
- ☐ Unable to communicate my needs
- ☐ Unable to recognize family or friends
- ☐ Total or near total dependence on others for care
- ☐ Other: _____

Check only one:

- ☐ Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).
- ☐ If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

SECTION 2: (You may leave this section blank)

Some people do not want certain treatments under any circumstance, even if they might recover.

Check the treatments below that you do not want under any circumstances:

- ☐ Cardiopulmonary Resuscitation (CPR)
- ☐ Ventilation (breathing machine)
- ☐ Feeding tube
- ☐ Dialysis
- ☐ Other: _____

SECTION 3:

When I am near death, it is important to me that: _____

_____

_____

_____

(Such as hospice care, place of death, funeral arrangements, cremation or burial preferences.)

BE SURE TO SIGN PAGE TWO OF THIS FORM

- If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.
- Talk about this form with the person you have chosen to make decisions for you, your doctors), your family and friends. Give each of them a copy of this form.
- Take a copy of this with you whenever you go to the hospital or on a trip.
- You should review this form often.
- You can cancel or change this form at any time.