

PATIENT WORKBOOK



About me

NAME
FIRST

LAST

DATE OF BIRTH

Decision Maker(s)

Primary Decision Maker

PRIMARY DECISION MAKER'S NAME
FIRST

LAST

RELATIONSHIP
TO ME

ADDRESS
STREET

/ CITY

/ STATE

/ ZIP

CONTACT INFO
EMAIL

PHONE

Secondary Decision Maker

SECONDARY DECISION MAKER'S NAME
FIRST

LAST

RELATIONSHIP
TO ME

ADDRESS
STREET

/ CITY

/ STATE

/ ZIP

CONTACT INFO
EMAIL

PHONE

- OR -

I choose NOT to name a health care decision maker. (CHECK BOX IF APPLIES)

My Quality of Life Preferences

The following prompts are related to your quality of life. Quality of life is about the things you are able to do or not do, and how much those things matter to you. It is important to consider what matters most to you and makes your life worth living. Some things matter more to certain people, and others matter less. Your document should express what matters most to you.

	<i>This is worse than dying comfortably</i>	<i>This is neither better nor worse than dying comfortably</i>	<i>This is better than dying comfortably</i>
I am confused all the time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I rely on a feeding tube to live	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I rely on a breathing machine to live	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I cannot control my bladder or bowels	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I need care all the time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I cannot live outside of a hospital or medical facility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have to stay at home all day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am in moderate pain all the time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I cannot get out of bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am wheelchair bound	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What else do you want your doctors to know about your quality of life goals?

My Medical Treatment Preferences

Life sustaining treatments replace or support bodily functions that are no longer working. When people have treatable conditions, life support is used temporarily until the illness or disease can be stabilized and the body can resume normal functioning. However, when a person becomes very sick, the body never regains the ability to function without life support or life-sustaining treatment. It is important to consider what treatments you would want your doctors to use long-term if you were not going to get better.

Now imagine that you are very sick. Your doctors tell you that you will not get better, and you may not have long to live. Overall, what do you want to be the goal of your medical care?

I want treatments to focus on comfort and my quality of life.

I want to focus on prolonging my life, but I only want to try life support treatments for a short time. If my doctors decide that the treatments are not helping, I want them stopped.

I want all treatments to prolong my life.

I only want some treatments to prolong my life. *(Select a list of treatments you want)*

Cardiac resuscitation

Cardiac resuscitation means pressing very hard on your chest and giving you shocks if your heart stops.

Breathing machine

A breathing machine, or ventilator, helps you breath. You cannot talk while you are connected to the ventilator.

Dialysis

Dialysis uses a special machine to clear your blood when your kidneys do not work.

Surgery

Chemotherapy for cancer

Artificial nutrition

Artificial nutrition is given through a feeding tube placed in your mouth, nose, or stomach. Sometimes nutrition is also given directly into the blood through a tube in a vein (IV).

Hydration

Fluid is given directly to the blood through a tube in a vein (IV).

Antibiotics

Antibiotics are given to treat infections. Sometimes they are taken as a pill. Other times they are given through a tube in a vein (IV).

Blood transfusions

Blood is given through a tube in a vein (IV).

Organ Donation

Donating your organs after you die can help save lives. A single person who chooses to donate organs after death can help save as many as 10 people. It's a way to give back and support others.

Everyone can sign up for organ donation and most people choose this option, regardless of age or illness. Even people with serious medical illnesses can donate their organs.

Choosing to be an organ donor doesn't affect your health care when you are alive. Our Care Wishes recommends choosing to donate your organs so you can help save or improve other people's lives.

Select one that applies:

After I die, I would like to donate any organs that can help someone else

- OR -

*After I die, I will donate all my organs **EXCEPT:***
(LIST ORGANS YOU CHOOSE NOT TO DONATE)

- OR - *I choose **NOT** to donate any of my organs.* (CHECK BOX IF APPLIES)

On behalf of myself, my executors and heirs, I hold my health care decision maker and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care decision maker's authority or in following my treatment instructions.

I, having carefully read this document, have signed it this _____ DAY _____ MONTH AND YEAR _____, revoking all previous health care powers of attorney and health care treatment instructions.

YOUR SIGNATURE
(SIGN HERE)

YOUR NAME
(PRINT HERE)

WITNESSES

WITNESSES MUST BE AT LEAST 18 YEARS OF AGE, KNOW YOU, AND SEE YOU SIGN THIS FORM. WITNESSES CANNOT BE YOUR HEALTH CARE DECISION MAKER OR HEALTH CARE PROVIDER.

By signing, I promise that _____ APPLICANT'S FULL NAME _____ signed this form while I watched. He/she was thinking clearly and was not forced to sign it.

WITNESS #1
SIGNATURE

FIRST NAME:

LAST NAME

CITY

STATE

ZIP CODE

WITNESS #2
SIGNATURE

FIRST NAME:

LAST NAME

CITY

STATE

ZIP CODE
