Williams Allen Casey LPA
Counselors at Law

Directives Regarding Health Care Decisions

_____
Print Name

I have memorialized my preferences regarding my health care within this document. If I am unable to effectively communicate my health care wishes, I direct my Health Care Power of Attorney agent, my Trustee, my family and all other interested parties to be guided by these instructions in making decisions regarding my health care.

Goals of Medical Treatment

1. With regard to the goals of any medical treatment, I have noted below the importance I place on the following issues regarding my quality of life: *[Initial appropriate box below]*

	Not Important	Low Importance	Neutral/ Undecided	Important	Very Important
Ability to speak					
Ability to communicate					
Ability to care for myself					
Ability to participate in activities I enjoy					
Ability to recognize family and friends					

2. Additional Instructions regarding Quality of Life: *[If none, write "None"]*

_____

_____

_____

Direction Regarding Life Sustaining Treatment

3. For the treatment of life threatening conditions that my physician believes have a **REASONABLE POSSIBILITY OF IMPROVEMENT**, below are my preferences for the short-term intervention of the following treatments. *[Initial appropriate box below]*

	Yes	No	Undecided
Artificial Nutrition – being fed through a tube in my stomach			
Artificial Hydration			
Intubation – a tube inserted down my throat to help me breathe			
Surgery			
Dialysis			
Invasive Testing			
Experimental Treatments			

4. Additional Instructions regarding Life Sustaining Treatment when there is a Reasonable Possibility of Improvement: *[If none, write "None"]*

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5. For the treatment of a condition that my physician believes is **IRREVERSIBLE**, below are my general preferences for interventions. *[Initial appropriate box below]*

	Yes	No	Undecided
Artificial Nutrition – fed through a tube in my stomach			
Artificial Hydration			
Intubation - a breathing tube inserted in my throat			
Surgery			
Dialysis			
CPR - chest compressions if my heart stops or I stop breathing			
Invasive Testing			
Chemotherapy			
Experimental Treatments			

6. Additional Instructions regarding treatment of irreversible conditions: *[If none, write "None"]*

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Direction Regarding A Terminal Illness & My End of Life Goals

I understand it is impossible to give direction regarding every possible medical scenario that may arise. My hope is that the following information with inform the decisions of my Health Care Agent and family.

7. If I have a terminal illness, I would best describe my goals related to medical treatment as: *[Initial one]*

   _____ Prolong life by all means available

   _____ Prolong life if treatments will not have a significant impact on my quality of life

   _____ Focus on quality of life and comfort, pursuing only minimally invasive procedures and treatments

   _____ Focus on comfort only and do not pursue any treatments, consider hospice care

8. If my physician believes I am in a terminal state, I would like my Health Care Agent to pursue a second opinion. *[Initial one]*

   _____YES _____NO _____UNDECIDED

9. If my physician recommends experimental treatment or inclusion in clinical trials, I am open to pursuing these types of treatments. *[Initial one]*

   _____YES _____NO _____UNDECIDED

10. If my physician determines I am in a terminal state, I direct my Health Care Agent to consult with my physicians regarding a do not resuscitate (DNR) order. *[Initial one]*

    _____YES _____NO _____UNDECIDED

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11. If my physician determines I am in a terminal state, I direct my Health Care Agent to consult my physicians regarding deactivating my ICD (implantable defibrillator) if applicable. *[Initial one]*

_____YES _____NO _____NOT APPLICABLE

12. I would prefer, to the extent possible, my Health Care Agent consult with members of my immediate family regarding withdrawal of treatment if applicable. *[Initial one]*

_____YES _____NO _____UNDECIDED

13. I am comfortable with my medical records/history being shared with members of my immediate family in order to assist in making decisions regarding my care. *[Initial one]*

_____YES _____NO _____UNDECIDED

14. I request my Health Care Agent consent to medication to relieve my pain as needed and recommended by my physician even if they reduce my responsiveness. *[Initial one]*

_____YES _____NO _____UNDECIDED

15. If I am in a terminal state, please contact the following individuals to advise them of my condition: *[If none, write "None"]*

_____

_____

_____

_____

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16. I direct my Health Care Agent to consider the additional information below regarding my preferences should I have a terminal illness: *[If none, write "None"]*

_____

_____

_____

_____

Direction Regarding Organ Donation

17. The following are my wishes regarding organ donation: *[Initial one]*

_____ I have registered as an organ donor and/or have designated that I would like to be an organ donor on my state driver's license or state identification.

_____ I have not registered as an organ donor but I am open to my Health Care Agent considering donation in collaboration with my health care provider and family.

_____ I do not wish to be an organ donor.

18. I direct my Health Care Agent consider the additional information below regarding organ donation: *[If none, write "None"]*

_____

_____

_____

_____

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Cultural and Religious Considerations

19. In accordance with my religious beliefs, I direct my Health Care Agent to refuse the following interventions: *[Initial one]*

    _____ Blood Transfusions

    _____ Organ Transplant

    _____ Use of Animal Based Medical Products

    _____ Not applicable

20. I direct my Health Care Agent consider the additional information below regarding my cultural and religious considerations: *[If none, write "None"]*

_____

_____

My Place of Worship

21. Name, address and phone number of my place of worship and my clergy member's name: *[If none, write "None"]*

_____

_____

_____

22. I would like my place of worship notified if I am ill or hospitalized. *[Initial one]*

    _____YES _____NO _____NOT APPLICABLE

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23. I would like to be included in the prayerful intentions of my congregation's services. *[Initial one]*

_____YES _____NO _____NOT APPLICABLE

24. I would like visitations from my clergy. *[Initial one]*

_____YES _____NO _____NOT APPLICABLE

25. My religious traditions include the Anointing of the Sick or Last Rites and I request my Health Care Agent contact my place of worship to arrange this on my behalf. *[Initial one]*

_____YES _____NO _____NOT APPLICABLE

26. I direct my Health Care Agent consider the additional information below regarding my cultural and religious preferences: *[If none, write "None"]*

_____

_____

Direction Regarding Long Term Care Preferences

27. Should I no longer be able to live independently, my first choice for living arrangements is: *[Initial one]*

_____Remain at home utilizing in-home assistance provided by an agency or family member.

_____Reside with a family member or close friend who is willing and able to provide the care I need.
Name:_____

_____Relocate to a long term care community that can meet my needs (assisted living or skilled nursing).

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28. I direct my Health Care Agent and the Trustee of my living trust consider the additional information below when making decisions regarding where I will reside: *[If none, write "None"]*

_____

_____

_____

Receiving Care at Home or in a Family Member's Home

29. I encourage my Health Care Agent to obtain all necessary services for me to remain in my home regardless of cost. *[Initial one]*

_____YES _____NO _____UNDECIDED

30. I encourage my Health Care Agent to seek assistance from the law firm of Williams Allen Casey Client Care Coordinator for assistance in identifying and implementing resources that will help me maintain my independence, continue residing in my home, or coordinating medical care. *[Initial one]*

_____YES _____NO _____UNDECIDED

31. If a family member or close friend resides with me in my home and provides services necessary to allow me to remain at home, I direct that no room or board fees be charged to this family member. *[Initial one]*

_____YES _____NO _____UNDECIDED

32. If modifications are needed to my home in order for me to safely remain there, I direct the Trustee of my living trust to pay for all reasonably necessary changes. *[Initial one]*

_____YES _____NO _____UNDECIDED

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33. If modifications are needed to the home of a family member or close friend in order for me to safely reside there, I direct my trustee to ensure payment for all reasonably necessary changes, even if such expenditures may result in an economic benefit to the family member or close friend. *[Initial one]*

_____YES _____NO _____UNDECIDED

34. If I live with a family member or close friend that can provide the assistance I require, I request my trustee to provide reasonable compensation to that individual. *[Initial one]*

_____YES _____NO _____UNDECIDED

35. I direct my Health Care Agent and the Trustee of my living trust consider the additional information below when making decisions regarding my care in my home or in the home of a family member or close friend: *[If none, write "None"]*

_____

_____

Long Term Care Facility

36. If relocation to a long term care facility is required, I prefer placement at the following facility: *[If none, write "None"]*

Name: _____

Address: _____

37. I qualify for placement in long term care facilities based on my military service, membership in a fraternal organization or because of some contractual agreement: *[Initial one]*

_____ No;

_____ Yes; Name of placement benefits:_____

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38. I have long term care insurance or financial investments that pay long term care expenses. Contact the law firm of Williams Allen Casey to secure assistance with filing claims for benefits. *[Initial one]*

_____YES _____NO _____UNCERTAIN

39. If I have not specified a facility above or do not have a preference, I direct my Health Care Agent prioritize the following. *[Number from 1-4 with 1 being the most important to you.]*

_____Facilities located in the community I live
_____Facilities near the majority of my family
_____Facilities that operate in accordance with my religious beliefs
_____Facilities that offer varying levels of care from assisted living to skilled nursing

40. I direct my Health Care Agent and/or my Trustee to consider the additional information below prior to making any decision regarding placement in a long-term care facility: *[If none, write "None"]*

_____

_____

_____

41. Additional instructions regarding my care: *[If none, write "None"]*

_____

_____

_____

_____

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I have consulted with legal counsel, am fully informed as to all the contents of this document, and understand the full import of the grant of these instructions to the persons named as agents in my Health Care Power of Attorney and/or Trustee.

_____

Signature

_____

Print Name

Date: _____

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