**HEALTH CARE DIRECTIVE QUESTIONNAIRE**

A health care directive allows you to select a “health care agent” to make health care decisions on your behalf if you are unable to decide or speak for yourself. Your health care agent has a legal duty to act in your best interest based on your health care instructions. Your spouse does not automatically have the general power to act on your behalf if you become incapacitated or incompetent without a health care directive. Having a health care directive avoids having a court appoint an agent to make health care decisions for you.

**PERSONAL INFORMATION**

Name: Click here to enter your full legal name.

Date of Birth: Click here to enter your D.O.B.

US Citizen? [ ]  Yes [ ]  No

Street Address: Click here to enter your street address.

County: Click here to enter the county you live in.

Telephone Number: Click here to enter your telephone number

Email: Click here to enter your email address.

**MARITAL STATUS:**

[ ]  Married

[ ]  Divorced

[ ]  Widowed

[ ]  Never Married

**SPOUSE OR SIGNIFICANT OTHER**

Name: Click here to enter your spouse’s full legal name.

Date of Birth: Click here to enter your spouse’s D.O.B.

US Citizen? [ ]  Yes [ ]  No

Street Address: Click here to enter your spouse’s street address.

County: Click here to enter the county your spouse lives in.

Telephone Number: Click here to enter your spouse’s telephone number.

Email: Click here to enter your spouse’s email.

**SELECTION OF HEALTH CARE AGENT**

Please identify the person who will serve as your health care agent. You can name both a primary and a successor health care agent. A successor health care agent will serve if your primary health care agent is unable or unwilling.

**Primary Agent**

[ ]  My spouse.

Another person:

Name: Click here to enter your agent’s name.

Relationship to you: Click here to enter your agent’s relationship to you.

Address: Click here to enter your agent’s full street address.

Telephone Number: Click here to enter your agent’s telephone number.

**Successor Agent**

Name: Click here to enter your agent’s name.

Relationship to you: Click here to enter your agent’s relationship to you.

Address: Click here to enter your agent’s full street address.

Telephone Number: Click here to enter your agent’s telephone number.

**POWERS GIVEN TO HEALTH CARE AGENT**

[ ]  (A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

[ ]  (B) Choose my health care providers.

[ ]  (C) Choose where I live and receive care and support when those choices relate to my health care needs.

[ ]  (D) Review my medical records and have the same rights that I would have to give my medical records to other people.

[ ]  (E) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

[ ]  (F) To decide what will happen with my body when I die (burial, cremation).

**HEALTH CARE INSTRUCTIONS**

Please carefully consider each of the scenarios below and select the choice that best suits your beliefs and values. Your answers to Questions 1 through 4 below only apply when your doctor informs you or your health care agent that nothing more can be done to improve your health or save your life. ***If you so choose, you do not need to answer any or all of these questions. In that case, your health care agent will have the authority to make decisions on your behalf based on what they believe you would want.***

1. If I am diagnosed as having an incurable and irreversible illness, disease, or condition and if my attending physician and at least one additional physician who has personally examined me determine my condition is terminal:

[ ]  I direct that life-sustaining treatment which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate treatment and care necessary to provide for my personal hygiene and dignity, to make me comfortable, and to relieve my pain.

[ ]  I direct that life-sustaining treatment be continued, if medically appropriate.

1. If there should come a time when I become permanently unconscious and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my ability to interact with other people and my surroundings:

[ ]  I direct that life-sustaining treatment be withheld or discontinued. I also direct that I be given all medically appropriate treatment and care necessary to provide for my personal hygiene and dignity, to make me comfortable, and to relieve my pain.

 [ ]  I direct that life-sustaining treatment be continued, if medically appropriate.

1. If there comes a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition which may not be terminal, but causes me to experience severe and worsening physical or mental deterioration, and it is determined by my attending physician and at least one additional physician who has personally examined me that I will never regain the ability to make decisions and express my wishes:

[ ]  I direct that life-sustaining treatment be withheld or discontinued. I also direct that I be given all medically appropriate treatment and care necessary to provide for my personal hygiene and dignity, to make me comfortable, and to relieve my pain.

 [ ]  I direct that life-sustaining treatment be continued, if medically appropriate.

1. If I am in any of the condition(s) described above, I feel especially strongly about the following forms of treatment: (*select all those that apply*)

[ ]  I do not want cardiopulmonary resuscitation (CPR)

[ ]  I do not want mechanical respiration

[ ]  I do not want tube feeding

[ ]  I do not want tube hydration

[ ]  I do not want antibiotics

[ ]  I DO want maximum pain relief, even if it may hasten my death

**END OF LIFE INSTRUCTIONS**

**Organ Donation Instructions**

[ ]  I DO NOT want to be an organ donor

[ ]  I DO want to be an organ donor

**Burial/Cremation Instructions**

[ ]  I want to be buried

[ ]  I want to be cremated

I would like to be buried in the following location Click here to enter text.

I would like my ashes to be Click here to enter text.

**OTHER HEALTH CARE INSTRUCTIONS**

Click here to enter text.