Treatment Preferences (Goals of Care)

(This section is optional, but recommended)

Print Name: _____ Date of Birth:_____

Specific Instructions to my Patient Advocate -

When I am not able to decide or speak for myself, the following are my specific preferences and values concerning my health care:

Instructions:

- *Put your initials (or "X") next to the choice you prefer for each situation below.*

TREATMENTS TO PROLONG MY LIFE

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, where I am, and I am unable to meaningfully interact with others:

____ I want all possible efforts to prolong life made on my behalf, even if it means I may remain on life-sustaining equipment, such as a breathing machine or kidney dialysis, for the rest of my life.

OR

____ I want my health care providers to try treatments to prolong my life for a period of time. However, I want to stop these treatments if they do not help, or if they cause me pain and suffering.

OR

____ I want to stop or withhold all treatments to prolong my life.

In all situations, I want to receive treatment and care to keep me comfortable.

____ ***I choose not to complete this section.***

(continues on next page)

Instructions:

- *Put your initials (or "X") next to the choice you prefer for each situation below.*
- *NOTE: This is NOT a "Do Not Resuscitate" (DNR) Order, which is a separate legal document. Talk with your personal healthcare provider if you would like a DNR Order.*

CARDIOPULMONARY RESUSCITATION (CPR)

If my heart or breathing stops:

____ I **want** CPR in all cases.

OR

____ I **want** CPR unless my health care providers determine that I have any of the following:

- An injury or illness that cannot be cured and I am dying.
- No reasonable chance of surviving.
- Little chance of surviving long term, and it would be hard and painful for me to recover from CPR.

OR

____ I ***do not want*** CPR but instead want to allow natural death.

Additional Specific Instructions

I want my Patient Advocate to follow these specific instructions, which may limit the authority previously described in General Instructions to My Patient Advocate.

_____

_____

_____

_____

____ ***I choose not to complete this section.***

Signature

(If you are satisfied with your choice of Patient Advocate and with the Treatment Preferences guidance you have provided in this section, you need to sign and date the statement below.)

I am providing these instructions of my own free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind. These are my preferences and goals expressed and affirmed on the date below:

Signature: _____ Date: _____