

SUPPLEMENTAL STATEMENT OF HEALTHCARE WISHES

Name: _____ Date of Birth: _____

Providing further details about how you want to be treated in specific situations will be helpful to your family, friends, and physicians. These details, and other wishes that you document here, will ensure that everyone knows what treatments you want to have and what treatments you want to avoid. Please put your initials by the statements that go along with your wishes, and please write in any further directions that are important to you. Always take a copy of this document to your medical appointments and any other healthcare settings. In addition, give a copy to your Healthcare Power of Attorney.

Pain Medication

- _____ I want to be free of pain, even if that means I am somewhat sedated.
- _____ I want to be as free of pain as possible, but I prefer to be alert, even if that means I have some residual pain.

Hospital Transfer

- _____ I want to go back to the hospital if there is no way, other than hospice, to handle my symptoms at home.
- _____ I never want to go back to hospital, even if my symptoms get worse and I know I might die at home. In this event, I agree to be referred to the hospital program of my choice for symptom control and end of life care in my home or at their inpatient unit: _____.

Code Status

If my heart stops or if I lose consciousness and stop breathing:

- _____ I want medical personnel to try to restore my heart beat by shocking me and giving me medications, or to put a tube in my lungs and breathe artificially for me.
- _____ I do not want medical personnel to try to restart my heart beat or to put a tube in my lungs and breathe artificially for me. I have signed an orange card and will display it on my refrigerator at home.

Hydration/Nutrition

- _____ I want medical personnel to administer fluids and nutrition in any situation in which I can not sustain my needs naturally.
- _____ I want medical personnel to administer fluids and nutrition only in the short term situation that I can not sustain my needs naturally and it seems that I have every chance of recovering to my full functional level.
- _____ I do not want medical personnel to administer fluids and nutrition in any event that I am unable to sustain my needs naturally.

Organ Donation

- _____ Yes
- _____ No

Body Donation

- _____ Yes
- _____ No

Signature _____ Date _____

Witness / Relationship _____ Date _____