ADVANCE MEDICAL DIRECTIVE QUESTIONNAIRE

The agent under a health care power of attorney has the power to make decisions on your behalf on a variety of health-related issues when you are incapacitated. A good agent is honest and loyal, understands your goals and beliefs regarding end-of-life care, does not live far away, and is mentally and physically capable of acting on your behalf when you are unwilling or unable. A secondary agent should be named as a back-up in case the primary agent is unwilling or unable to serve.

Designate your primary agent, and at least one alternate agent. Include contact information for each.

I. Primary Agent:

Name: _____

Relation to You: _____

Address: _____

City / State / Zip: _____ / _____ / _____

Home Phone: _____

Cell Phone: _____

Email: _____

II. First Alternative Agent:

Name: _____

Relation to You: _____

Address: _____

City / State / Zip: _____ / _____ / _____

Home Phone: _____

Cell Phone: _____

Email: _____

III. Second Alternative Agent:

Name: _____

Relation to You: _____

Address: _____

City / State / Zip: _____ / _____ / _____

Home Phone: _____

Cell Phone: _____

Email: _____

IV. Third Alternative Agent:

Name: _____

Relation to You: _____

Address: _____

City / State / Zip: _____ / _____ / _____

Home Phone: _____

Cell Phone: _____

Email: _____

Health Care Treatment:

If I am in a coma or in a persistent vegetative state, and if after a period of at least three months two physicians agree that I will never again be able to think or recognize anyone or do even simple things like eating, walking, or caring for my own hygiene, then I direct the following:

1. **Cardiopulmonary Resuscitation (CPR)**:
   - ☐ Perform
   - ☐ Do NOT perform
   - ☐ Let my Agent decide

2. **Mechanical Breathing**: If, after diagnosis, I require medical assistance with breathing:
   - ☐ Connect me to a respirator
   - ☐ Do NOT connect met to a respirator
   - ☐ Connect me for a trial period. Remove me if my condition does not improve.
   - ☐ Let my Agent decide

3. **Tube Feeding**:
   - ☐ I want to be tube-fed
   - ☐ I do NOT want to be tube-fed
   - ☐ Tube-fed me for a trial period. End if my condition does not improve.
   - ☐ Let my Agent decide

4. **Kidney Dialysis**:
   - ☐ Put me on dialysis
   - ☐ Do NOT put me on dialysis
   - ☐ Put me on dialysis for a trial period. End dialysis if my condition does not improve.
   - ☐ Let my Agent decide

5. **Diagnostic Tests**:
   - ☐ Perform necessary diagnostic test
   - ☐ Do NOT perform diagnostic tests
   - ☐ Only perform if they are necessary to determine the cause of my pain.
   - ☐ Let my Agent decide

6. **Minor Surgery**:
   - ☐ Perform necessary minor surgery
   - ☐ Do NOT perform minor surgery
   - ☐ Only perform if it is necessary to determine the cause of my pain.
   - ☐ Let my Agent decide

7. **Major Surgery**:
   - ☐ Perform necessary major surgery
   - ☐ Do NOT perform major surgery
   - ☐ Only perform if it is necessary to determine the cause of my pain.
   - ☐ Let my Agent decide

8. **Chemotherapy**:
   - ☐ I want chemotherapy
   - ☐ I do NOT want chemotherapy
   - ☐ Perform chemotherapy for a trial period. End if my condition does not improve.
   - ☐ Let my Agent decide

9. **Blood Transfusion**:
   - ☐ I want to receive blood transfusions
   - ☐ I do NOT want to receive blood transfusions
   - ☐ I want blood transfusions for a trial period. End if my condition does not improve.
   - ☐ Let my Agent decide

10. **Antibiotics**:
    - ☐ I want to receive antibiotics
    - ☐ I do NOT want to receive antibiotics
    - ☐ I want to receive antibiotics for a trial period. End if my condition does not improve.
    - ☐ Let my Agent decide

11. **Pain Medication and Comfort Care**:
    - ☐ If I am in pain, I want to receive enough medication to stop the pain.
    - ☐ I do NOT want to receive pain medication
    - ☐ Let my Agent decide
    - ☐ I want to be kept clean, turned frequently, and receive whatever other care is necessary to maintain my dignity.

12. **Additional Comments**: If you want to add any further instructions or clarifications regarding your healthcare treatment, please use the space provided here:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Instructions over Agent:

You have the choice to either: (1) require your agent be bound to the instructions contained within your Advanced Medical Directive; or (2) allow your agent to use the instructions as guidance and potentially override your instructions, subject to any specific limitations. Please indicate your preference:

My health care agent MUST FOLLOW these instructions.

Or

My health care agent may treat these instructions as only guidance, and shall have the final say and may override my instructions, subject to the following limitations:

_____
_____
_____
_____

Organ Donations:

Do you consent to donate your organs, tissues, or any other part or all of your body at the time of your death? Yes No

If yes, please check all that apply:

- ☐ I consent to the donation for BOTH medical study and transplants.
- ☐ I consent to the donation ONLY for medical study.
- ☐ I consent to the donation ONLY for transplants.
- ☐ I consent to the donation subject to the following limitations:

_____
_____
_____
_____