This PDF file has Eleven (11) Living Will excerpts for you to read. Then you can answer the survey questions to express your opinions.

Some Living Will excerpts are only one page long, but a few are longer.

*Suggestions for initial reading and subsequent viewing:*

For your initial reading, view at page width (with scrolling). Click on the icon in the task bar that shows a double arrow on a page. The icon looks like this:

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To review these Living Will excerpts as you express your opinions, you may find it more convenient to use the “Two Page View.” You can select this under Page Display, which is in turn, under View. That way, you can review two full pages at a time.

You can identify each Living Will by its number in brackets [#] and by the words in the title and first few words that the survey refers to.
Living Will

I, __________________________________________ am of sound mind, and I voluntarily make this declaration.

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honored as the expression of my legal right to authorize or refuse medical treatment.

My desires concerning medical treatment are:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

(Attach additional sheets if you wish)

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

i Note: The names of all the Living Wills (or excerpts) and the authors/sponsors are not included to avoid possible bias. They will be revealed to Subjects who request the full version of any form that they intend to use for their personal Advance Care Planning.
HEALTH CARE INSTRUCTIONS

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

My Wishes

Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. If I have not given specific instructions, then my agent must decide consistent with my wishes and beliefs.

* Medical treatments may be withdrawn or avoided if they do not offer a reasonable hope of benefit to me or are excessively burdensome.

* There should be a presumption in favor of providing me with nutrition and hydration if they are of benefit to me. In principle, there is an obligation to provide food and water (employing medically assisted nutrition and hydration for those who cannot take food orally) to all patients, including those in chronic and presumably irreversible conditions. Medically assisted nutrition and hydration, however, become morally optional when they cannot reasonably be expected to prolong life, when they would be excessively burdensome for the patient, or when they would cause significant physical discomfort.

* In accord with the teachings of my religion, I have no moral objection to the use of medication or procedures necessary for my comfort, even if they may indirectly and unintentionally shorten my life.

* If my death is imminent, I direct that treatment that will maintain only a precarious and burdensome prolongation of my life should be withdrawn or avoided, unless those responsible for my care judge at that time that there are special and significant reasons why I should continue to receive such treatment.

In addition to the “My Wishes” section, above, I would like you to know these further things about me to help you make decisions about my health care:

My goals for my health care:

My fears about my health care:

My beliefs about when medical interventions to prolong my life are no longer of benefit to me:

My thoughts about how my medical condition might affect my family:
THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE
(I know I can change these choices or leave any of them blank.)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:
(Note: You can describe general feelings, specific treatments, or leave any of them blank, but each should be discussed thoroughly by patients and health care agents.)

________________________________________________________________________

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:

________________________________________________________________________

If I were dying and unable to decide or speak for myself, I would want: __________

________________________________________________________________________

If I were permanently unconscious and unable to decide or speak for myself, I would want: __________

________________________________________________________________________

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:

________________________________________________________________________

In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life: __________

________________________________________________________________________

There are other things that I want or do not want for my health care, if possible:
Who I would like to have as my doctor: ___________________________________________________________________

Where I would like to live to receive health care: __________________________

Where I would like to die, and other wishes I have about dying: __________

Any other things: ____________________________________________________________________________
“Will to Live”

(Suggestions:) If you choose to fill out any part of the “SPECIAL CONDITIONS” sections of this Will to Live form, you must be very specific in listing what treatments you do not want... because... there is great danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want...
For example, do not simply say you don’t want “extraordinary treatment” [because]... it might be interpreted to require starving you to death when you have a disability, even if you are in no danger of death if you are fed.

Do not use language that rejects treatment such as “excessive pain, expense or other excessive burden,” or rejects treatment that “does not offer a reasonable hope of benefit.”

What sort of language is specific enough? (Examples:) “Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer,” and, “A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me,” and, “I would like medication to relieve my pain but only to the extent it is known, to a reasonable medical certainty, that it will not shorten my life.” Remember that how carefully you write may literally be a matter of life or death--your own.

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and agent(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and agent(s) to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:
   · the administration of medication;
   · cardiopulmonary resuscitation (CPR); and
   · the performance of all other medical procedures, techniques, and technologies, including surgery,
   --all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.
I also direct that I be provided basic nursing care and procedures to provide comfort care.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the “quality” of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and agent(s) to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my agent, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn: (Be as specific as possible; SEE SUGGESTIONS.):  

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn: (Be as specific as possible; SEE SUGGESTIONS.):  

C. OTHER SPECIAL CONDITIONS: (Be as specific as possible; SEE SUGGESTIONS.):

(The form provides blank lines for A, and B, and C:)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)
This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

GOALS

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome.

I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials______ I agree 
Initials______ I disagree

PART III

HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS (LIVING WILL)

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make, or communicate my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply (cross out any treatment instructions with which you do not agree):
1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

   - heart-lung resuscitation (CPR)
   - mechanical ventilator (breathing machine)
   - dialysis (kidney machine)
   - surgery
   - chemotherapy radiation treatment
   - antibiotics

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

(Initial only one statement.)

**TUBE FEEDINGS**

[_] I want tube feedings to be given.

OR

**NO TUBE FEEDINGS**

[_] I do not want tube feedings to be given.

---

**HEALTH CARE AGENTS USE OF INSTRUCTIONS**

(Initial one option only.)

[_] My health care agent must follow these instructions.

OR

[_] These instructions are only guidance.

My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions)

If I did not appoint a health care agent, these instructions shall be followed.
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

[Initials] (a) Choice Not To Prolong Life

I do not want my life to be prolonged if
(1) I have an incurable and irreversible condition that will result in my death within a relatively short time,
(2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or
(3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

[Initials] (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

________________________________________
________________________________________

(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.)

I direct that: __________________________________________
________________________________________

(Add additional sheets if needed.)
This section of the advance directive form is called a Living Will. This section of it lets you write down how you want to be treated in case you aren't able to decide for yourself anymore. Its purpose is to help others decide about your care.

### SPECIFIC PREFERENCES ABOUT LIFE-SUSTAINING TREATMENTS

In this section, you can indicate your preferences for life-sustaining treatments in certain situations. Some examples of life-sustaining treatments are:

- CPR (cardiopulmonary resuscitation)
- a breathing machine (mechanical ventilation)
- kidney dialysis
- a feeding tube (artificial nutrition and hydration)

Think about each situation described on the left and ask yourself, “In that situation, would I want to have life-sustaining treatments?” Place your initials in the box that best describes your treatment preference. You may complete some, all, or none of this section. Choose only one box for each statement.

<table>
<thead>
<tr>
<th>Yes.</th>
<th>I would want life-sustaining treatments.</th>
<th>I'm not sure. It would depend on the circumstances.</th>
<th>No.</th>
<th>I would not want life-sustaining treatments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.</td>
<td>Initials</td>
<td>Initials</td>
<td>Initials</td>
<td></td>
</tr>
<tr>
<td>If I have permanent, severe brain damage that makes me unable to recognize my family or friends (for example, severe dementia).</td>
<td>Initials</td>
<td>Initials</td>
<td>Initials</td>
<td></td>
</tr>
<tr>
<td>If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).</td>
<td>Initials</td>
<td>Initials</td>
<td>Initials</td>
<td></td>
</tr>
<tr>
<td>If I need to use a breathing machine and be in bed for the rest of my life.</td>
<td>Initials</td>
<td>Initials</td>
<td>Initials</td>
<td></td>
</tr>
<tr>
<td>If I have pain or other severe symptoms that cause suffering and can't be relieved.</td>
<td>Initials</td>
<td>Initials</td>
<td>Initials</td>
<td></td>
</tr>
<tr>
<td>If I have a condition that will make me die very soon, even with life-sustaining treatments.</td>
<td>Initials</td>
<td>Initials</td>
<td>Initials</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Initials</td>
<td>Initials</td>
<td>Initials</td>
<td></td>
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### HOW STRICTLY YOU WANT YOUR PREFERENCES FOLLOWED

Place your initials in the box next to the statement that reflects how strictly you want others to follow your preferences. Choose only one.

<table>
<thead>
<tr>
<th>Initials</th>
<th>I want my preferences, as expressed in this Living Will, to serve as a <strong>general guide</strong>. I understand that in some situations, the person making decisions for me may decide something different from the preferences I express above, if they think it's in my best interests.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initials</td>
<td>I want my preferences, as expressed in this Living Will, to be followed <strong>strictly</strong>, even if the person making decisions for me thinks that this isn't in my best interests.</td>
</tr>
</tbody>
</table>
My Wish For The Kind Of Medical Treatment
I Want Or Don't Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What “Life-Support Treatment” Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive.

If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a Do Not Resuscitate form or bracelet. Many states require a person to have a Do Not Resuscitate form filled out and signed by a doctor. This form lets ambulance personnel know that you don’t want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a Do Not Resuscitate form filled out.
Here is the kind of medical treatment that I want or don’t want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and all others to know these directions.

**Close to death:**
If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life support treatment would only delay the moment of my death (Choose one of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

**Permanent And Severe Brain Damage And Not Expected To Recover:**
If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose one of the following):

- I want to have life support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

**In A Coma And Not Expected To Wake Up Or Recover:**
If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (Choose one of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

**In Another Condition Under Which I Do Not Wish To Be Kept Alive:**
If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write “end-stage condition” That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)
The Dementia Provision

Most Advance Directives become operative only when a person is unable to make health care decisions and is either “permanently unconscious” or “terminally ill.” There is usually no provision that applies to the situation in which a person suffers from severe dementia but is neither unconscious nor dying.

The following language can be added to any Advance Directive or Living Will. There it will serve to advise physicians and family of the wishes of a patient with Alzheimer’s Disease or other forms of dementia. You may simply sign and date this form and include it with the form My Particular Wishes in your Advance Directive.

If I am unconscious and it is unlikely that I will ever become conscious again, I would like my wishes regarding specific life-sustaining treatments, as indicated on the attached document entitled My Particular Wishes to be followed.

If I remain conscious but have a progressive illness that will be fatal and the illness is in an advanced stage, and I am consistently and permanently unable to communicate, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve, I would like my wishes regarding specific life-sustaining treatments, as indicated on the attached document entitled My Particular Wishes to be followed.

If I am unable to feed myself while in this condition

I do / do not (circle one) want to be fed.

I hereby incorporate this provision into my durable power of attorney for health care, living will and any other previously executed advance directive for health care decisions.

__________________________  __________________________
Signature                                     Date
Below are 10 illustrated & described conditions (excerpted from a total of 48). Decide for each:

Would you want “Treat & Feed” — so your doctors will give you all reasonable treatments to try to keep you alive as long as possible? Or

Would you want “Consider Natural Dying” — so your proxy/agent and physician can decide when “that time” comes? Or

Would you want “Natural Dying” — so you can be allowed to die of your underlying disease? ➔

[ ] CHECK WHICH TREATMENT YOU WANT.

“I cannot say or show what I want—by using words, moving my hands, or changing the look on my face.” [2.1]

➢ Decide which treatment you want:
[ ] Natural Dying; [ ] Consider Natural Dying; [ ] Treat & Feed.

“Natural Dying” means to stop ALL life-sustaining treatments, including hand-feeding by another, to put food and fluid in your mouth (if you depend on it). Food and fluid will always be offered by placing them in front of you. You will receive all the Comfort Care you need so you suffer as little as possible.

Dying from medical dehydration usually occurs within two weeks. Aids to reduce thirst can make it quite comfortable.

“I do not seem to know it is me when I look in the mirror. I cannot tell others anything about me.” [1.1]

➢ Decide which treatment you want:
[ ] Natural Dying; [ ] Consider Natural Dying; [ ] Treat & Feed.
I have severe pain. But I cannot say what bothers me.

Doctors don’t see my pain. They do not treat my pain.

Directions: Decide which treatment you want: □ Natural Dying; □ Consider Natural Dying; □ Treat & Feed. [2.6]

When I see people in my close family or see my best friends, I do not know who they are.

Directions: Decide which treatment you want: □ Natural Dying; □ Consider Natural Dying; □ Treat & Feed. [3.1]

As others come in and say hello, or as they leave and say goodbye—I cannot say anything or move a part of my body.

Directions: Decide which treatment you want: □ Natural Dying; □ Consider Natural Dying; □ Treat & Feed. [3.2]

I do not use bathrooms. I let my clothes get wet and dirty. Others must change my diapers (nappies).

Directions: Decide which treatment you want: □ Natural Dying; □ Consider Natural Dying; □ Treat & Feed. [4.5]
I fear something horrible will happen to me. I see things or hear things.
I may know that what I see or hear is not real—but still, I feel very scared. [5.4]

So I do not hurt others or myself, doctors must give me a lot of medicine. This way, they will not need to tie me down. Otherwise if I get angry, I may hit people—even those who are nice to me. [5.6]

Doctors and medicines can keep me alive, but cannot make me feel better.
I will get sicker until I die. [6.3]

Food could go down the “wrong way.” If it enters my lungs, I could get very sick (pneumonia).

 Decide which treatment you want:
[ ] Natural Dying; [ ] Consider Natural Dying; [ ] Treat & Feed.

 Decide which treatment you want:
[ ] Natural Dying; [ ] Consider Natural Dying; [ ] Treat & Feed.

 Decide which treatment you want:
[ ] Natural Dying; [ ] Consider Natural Dying; [ ] Treat & Feed.

 Decide which treatment you want:
[ ] Natural Dying; [ ] Consider Natural Dying; [ ] Treat & Feed.
PART 2  Make your own health care choices

Write down your choices so those who care for you will not have to guess.

- Think about what makes your life worth living.
  - My life is only worth living if I can:
    - Put an X next to all the sentences you most agree with.
      - talk to family or friends
      - wake up from a coma
      - feed, bathe, or take care of myself
      - be free from pain
      - live without being hooked up to machines
      - I am not sure
  - or
  - My life is always worth living no matter how sick I am

- If I am dying, it is important for me to be:
  - at home  ☐  in the hospital  ☐  I am not sure

- Is religion or spirituality important to you?
  - no  ☐  yes  ☐  If you have one, what is your religion?

- What should your doctors know about your religion or spirituality?

---

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.
Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Put an X next to the one choice you most agree with. Please read this whole page before you make your choice.

☐ If I am so sick that I may die soon:

☐ Try all life support treatments that my doctors think might help.

If the treatments do not work and there is little hope of getting better, I want to stay on life support machines.

or

☐ Try all life support treatments that my doctors think might help.

If the treatments do not work and there is little hope of getting better, I do not want to stay on life support machines.

or

☐ Try all life support treatments that my doctors think might help but not these treatments. Mark what you do not want.

☐ CPR

☐ feeding tube

☐ dialysis

☐ blood transfusion

☐ breathing machine

☐ medicine

☐ other treatments ____________________________

or

☐ I do not want any life support treatments.

or

☐ I want my health care agent to decide for me.

or

☐ I am not sure.
Advance Directive for Dementia

For the circumstance in which I develop severe dementia, I define that stage in two ways.

First, by stages 6 and 7 of the Functional Assessment Staging Test (see addendum 1).  

Second, I include my personal definition: when I am no longer able to recognize family or friends, am no longer engaged in the life activities listed above or any new activities, and no longer demonstrate enthusiasm or joy. I understand that my proxy will need to use judgment regarding when I have reached severe dementia.

If I enter into severe dementia, I do not want the following measures to keep me alive:

• heart resuscitation (CPR or defibrillation)

• artificial breathing (ventilation)

• antibiotics for infections

• artificial hydration (IV fluids or nasogastric tube)

• artificial nutrition (nasogastric tube, PEG tube or jejunostomy tube). . .

Regarding eating and drinking once I am in severe dementia:

• If I am receptive to eating and drinking (i.e., show signs of anticipation and enjoyment), I want comfort feeding only. It is OK to spoon feed me any foods I like—and any texture that works—but please stop when I indicate I want no further food or drink or if I begin to choke or cough. I do want not to be cajoled, harassed, or in any way forced to eat.

• If I decline or resist food and water, please stop food and water per protocol in addendum 2 and continue comfort care.

• If I am indifferent to food and water, please stop food and water per protocol in addendum 2 and continue comfort care.

• In the circumstances where I have indicated above that I want not to be fed, if I then show distress, please do not resume feeding, but use distress-relieving drugs.
1) **Definition of severe dementia using the Functional Assessment Staging Test scale.**
I have included description of both stage 6 (moderately severe) and 7 (very severe, late stage) because progressive dementia does not necessarily advance in a linear fashion. When a majority of symptoms of both stages are present, I feel the stage of severe dementia is met. I acknowledge that this will require interpretation by my proxy and willingly allow room for reasonable interpretation.

**Stage 6, Severe Cognitive Decline (including Moderately Severe or Mid-Stage Alzheimer’s).**
Among the marks of this stage are that individuals
- lose most awareness of recent experiences and events as well as of their surroundings
- recollect their personal history imperfectly, although generally know their name
- forget name of spouse or caregiver but generally can recognize faces
- need help getting dressed
- need help with toileting
- have increased episodes of incontinence (both urinary and fecal)
- experience personality changes & behavior symptoms, including suspiciousness, delusions, hallucinations, or compulsive, repetitive behaviors such as hand-wringing or tissue shredding
- tend to wander and become lost

**Stage 7, Very Severe Cognitive Decline (including Severe or Late-Stage Alzheimer’s).**
Among the marks of this stage are that individuals
- lose ability to talk, although occasional phrases may be uttered
- have swallowing impairments, often causing aspiration
- need help with eating and toileting
- have urinary and fecal incontinence
- lose the ability to walk without assistance, then the ability to sit without support, the ability to smile, and the ability to hold their head up; reflexes become abnormal and muscles grow rigid

2) **Protocols for stopping food and water.**
- Stop food first, for 1-3 weeks depending on the initial strength and vigor of the individual. Then stop liquids and attend to mouth care and provide other relevant comfort care. Or,
- Stop food and water simultaneously and then attend to mouth care and provide other relevant comfort care.
Which protocol to use should be determined by discussion between my proxy decision-maker and my primary medical and nursing care providers.