ADVANCE HEALTH CARE DIRECTIVE QUESTIONNAIRE

Name: ____

Agent Name: ____
Agent Address: ____
Agent Phone Number: _________________________

Desires Regarding Life-Prolonging Treatment
(please check one)

______ I do not wish to receive medical treatment if I am in an irreversible coma or persistent vegetative state, or terminal illness and life sustaining procedures would only artificially delay death; or otherwise if burdens of treatment outweigh expected benefits.

______ I want to receive medical treatment unless I am in an irreversible coma.

______ I want to preclude use of life sustaining procedures if I am in a terminable condition.

______ I want to receive medical treatment that will allow me to live as long as possible.

Do you wish to make any additional statements regarding treatment? If so, please state below:
____
____
____
____
____

Anatomical Gifts (Please check one)

______ Attorney in fact authorized to make any anatomical gifts

______ Attorney in fact authorized to make anatomical gifts of specific parts
Please specify:
____
____

______ Attorney in fact not authorized to make anatomical gifts

If authorizing anatomical gifts:

______ Anatomical gifts are limited to the following purposes (if any):

______ Education ______ Transplant ______ Therapy ______ Research

Powers Regarding Disposal of Remains

______Yes ______No Attorney in fact authorized to dispose of your remains

If yes, please check one of the following:

______Yes ______No Disposal in attorney in fact's discretion

______Yes ______No Disposal according to your expressed wishes

Autopsy

______Yes ______No Attorney in fact authorized to okay an autopsy

Organ Donation

______ Yes ______No Attorney in fact authorized to okay organ donation.

Primary Physician (optional)

Name
Address
Phone Number