

ADVANCE HEALTH CARE DIRECTIVE QUESTIONNAIRE

Name: _____

Agent Information:

Name: _____

Address: _____

Phone: _____

Alternate Agent Information:

Name: _____

Address: _____

Phone: _____

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

Please state wishes for disposal of remains: _____

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

Name _____

Address _____

Phone Number _____