MY CHOICES, MY LIVING WILL

On this _____ day of ______________________, 2_____. I ______________________________________ willfully and voluntarily make known my desires to my family, doctors, hospitals, medical care providers and all others concerned with my care. These are my choices for care and treatment if, under the circumstances expressed below, I am mentally or physically incapacitated to the extent that I am unable to communicate my choices, desires, and preferences on my own.

If my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct the following:

DEFINITIONS

TREATMENT CHOICES

Comfort Measures Only: Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Transfer to the hospital ONLY if comfort needs cannot be met in my current location.

Limited Additional Interventions: In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

Time-Limited Full Treatment: In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation as indicated. Transfer to hospital if indicated. Includes intensive care. In the event that Full Treatments are no longer helping my health, but are only serving to prolong artificially the process of dying, I choose to have those treatments discontinued and to be provided with Comfort Measures Only.

Full Treatment: In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation as indicated. Transfer to hospital if indicated. Includes intensive care.

NUTRITION AND HYDRATION CHOICES

Comfort Measures Only: I do not want any artificial means of nutrition or hydration. Offer food by mouth if feasible and desired. Maximize my diet to allow me comfort foods of my choosing and nutritional supplements as tolerated. If I am no longer able to eat, provide me with good oral care; moisten my mouth and lips frequently to ensure comfort.

Limited Additional Artificial Nutrition: I would like a trial period of artificial nutrition and hydration including IV fluids, feeding tubes and/or TPN.

Long-term artificial nutrition and hydration: I would like artificial nutrition and hydration, including IV fluids, feeding tubes and/or TPN.

If I have a Terminal Condition, and I am seriously ill with a life-threatening condition

I choose one of the following medical interventions (as defined above), by initialing below:

____ **Comfort Measures Only**

____ **Limited Additional Interventions**

In addition, I choose one of the options below:

___ Transfer to hospital only if comfort needs cannot be met in current location

___ Transfer to hospital if indicated.

____ **Time-Limited Full Treatment**

____ **Full Treatment**

____ **Additional Choices:**

____

I make one of the following nutrition and hydration choices (as defined above), by initialing below:

____ **Comfort Measures Only**

____ **Limited Additional Artificial Nutrition**

____ **Long-term artificial nutrition and hydration**

____ **Additional Choices:**

____

If I am End Stage, and I am likely to die within a short period of time

I choose one of the following medical interventions (as defined above), by initialing below:

____ **Comfort Measures Only**

____ **Limited Additional Interventions**

In addition, I choose one of the options below:

___ I want additional interventions stopped, when it is determined that I can no longer expect to recover, and want to receive Comfort Measures only

___ Transfer to hospital only if comfort needs cannot be met in current location

___ Transfer to hospital if indicated.

____ **Full Treatment**

In addition, I choose the option below:

____ I want full treatment stopped when it is determined that I can no longer expect to recover, and want to receive comfort measures only.

____ **Additional Choices:**

____

I make one of the following nutrition and hydration choices (as defined above), by initialing below:

____ **Comfort Measures Only**

____ **Limited Additional Artificial Nutrition**

____ **Long-term artificial nutrition and hydration**

____ **Additional Choices:**

____

If I am in a Persistent Vegetative State, have permanent and severe brain damage, and I am not expected to recover

I choose one of the following medical interventions (as defined above), by initialing below:

____ **Comfort Measures Only**

____ **Limited Additional Interventions**
In addition, I choose one of the options below:
___ I want additional interventions stopped, when it is determined that I can no longer expect to recover, and want to receive Comfort Measures only.
___ Transfer to hospital only if comfort needs cannot be met in current location
___ Transfer to hospital if indicated.

____ **Full Treatment**
In addition, I choose the option below:
____ I want full treatment stopped when it is determined that I can no longer expect to recover, and want to receive comfort measures only.

____ **Additional Choices**:
____

I make one of the following nutrition and hydration choices (as defined above), by initialing below:

____ **Comfort Measures Only**
____ **Limited Additional Artificial Nutrition**
____ **Long-term artificial nutrition and hydration**
____ **Additional Choices:**
____

When my condition is Terminal and I have a life expectancy of six months or less, if the disease or condition follows its normal course, I choose to receive:

____ **Hospice services provided by Trustbridge, Inc.** If I no longer reside in their service areas, my health care decision maker will choose the hospice provider for me.

____ **Hospice services provided by** ____________________. If I no longer reside in its service area, my health care decision maker will choose the hospice provider for me.

____ **Hospice services from a provider of my health care decision maker's choice.**

DESIGNATION OF HEALTH CARE SURROGATE

I choose the following by initialing below:

____ I do **Not** wish to execute a Designation of Health Care Surrogate (Agent) at this time. Write "None" in the space provided below for agent's name, sign and have witnessed.

____ I have previously executed a Health Care Agent document which is currently in effect.

____ I appoint the following person to be my agent to make health care decisions for me **WHEN AND ONLY WHEN** I lack the capacity to make or communicate a choice regarding a particular health care decision and my Health Care Treatment Directive does not adequately cover circumstances. I request that the person serving as my agent be my guardian/proxy if one is needed.

Agent Name: ____ **Phone:** ________________

Address: ____

____ **ZIP**________________

If my agent is not available or not willing to make health care decisions for me or, if my agent is my spouse and is legally separated or divorced from me, I appoint the person or persons named below (in the order named if more than one listed) as my agent: **(It is not necessary to name an alternate agent.)**

First Alternate:	**Second Alternate**
Print Name: ____________________	Print Name: ____________________
Street: ____________________	Street: ____________________
City: ____________________	City: ____________________
State: __________ Zip: __________	State: __________ Zip: __________
Phone: ____________________	Phone: ____________________

I understand the full significance of this document and am emotionally and mentally competent to make these choices.

Signed ____________________ **Initial** __________ **Date:** __________

WITNESS:	**WITNESS:**
Print Name: ____________________	Print Name: ____________________
Street: ____________________	Street: ____________________
City: ____________________	City: ____________________
State: __________ Zip: __________	State: __________ Zip: __________
Phone: ____________________	Phone: ____________________
Signature: ______________ Date:________	Signature: ______________ Date________

AT LEAST ONE WITNESS MUST NOT BE A HUSBAND, WIFE OR BLOOD RELATIVE OF THE INDIVIDUAL IDENTIFIED ABOVE.
If Health Care Surrogate has been designated, the Health Care Surrogate may NOT be a witness