



STATEMENT OF WISHES – ATTACHMENT TO HEALTH CARE DIRECTIVE

This document is designed to provide your loved ones with a statement of certain health care wishes. Ideally, this guides what you would want to happen under certain circumstances. This is designed to be attached to any relevant health care document, including, but not limited to, a health care power of attorney, advance health care directive, living will, or health care proxy.

End-of-Life Wishes

- ☐ To Prolong Life
- ☐ Not to Prolong Life – Any Circumstances (Permanently Unconscious OR Terminal Condition)
- ☐ Not to Prolong Life – Permanently Unconscious
- ☐ Not to Prolong Life – Terminal Condition
- ☐ Other: _____

Artificial Nutrition and Hydration

- ☐ To Receive Artificial Nutrition and Hydration – Indefinitely
- ☐ To Receive Artificial Nutrition and Hydration – unless it increases my suffering and is no longer in my best interest.
- ☐ To Receive Artificial Nutrition and Hydration – on a limited trial basis to see if I can improve.
- ☐ I Do Not wish to Receive Artificial Nutrition and Hydration.
- ☐ Other: _____

Relief from Pain

☐ To always have adequate relief from pain, alleviating pain and discomfort.

☐ Other: _____

Anatomical Gift(s) at Death

☐ Organs

☐ Tissues

☐ All Body Parts

☐ No Anatomical Gift

☐ Other: _____

Anatomical Gift(s) Are Intended for the Following Purpose(s):

☐ Transplant

☐ Therapy

☐ Research

☐ Education

☐ All the Above

☐ Other: _____

Provide Anatomical Gifts To:

☐ No preference

☐ Other: _____

Other Wishes

Physical Health Treatments:

- ☐ I am okay with whatever needs to be done.
- ☐ I Do Not want any Physical Health Treatments.
- ☐ My Health Care Agent or attending physician may decide.
- ☐ Other: _____

Mental Health Treatments:

- ☐ I am okay with whatever needs to be done.
- ☐ I Do Not want any Mental Health Treatments.
- ☐ My Health Care Agent or attending physician may decide.
- ☐ Other: _____

Autopsy:

- ☐ Yes
- ☐ No
- ☐ My Health Care Agent may decide.
- ☐ Other: _____

Funeral and Burial:

- ☐ Buried
- ☐ Cremated
- ☐ My Health Care Agent may decide.
- ☐ I have prepaid funeral arrangements and will include these with my estate plan.
- ☐ Other: _____

Do Not Resuscitate (DNR):

☐ I have a DNR.

☐ I do not have a DNR.

DATE: _____

CLIENT SIGNATURE: _____