Name_____ DOB_____

Choices in Caring

Your doctor and health care team may be able to help give you the best care if he/she understands your views of what is important to you about medical treatment choices. These choices may change, and it is important to review these periodically with your doctor and health care team.

If you were to become seriously ill, and medical treatment decisions were to be made for you, how would you feel about the following statements?

1. I would want my care to be at a place nearby family members.
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

2. It is important to try medical treatments, including those that might only have a small chance of working.
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

3. The comfort or discomfort of medical treatments should be considered along with the hope of prolonging life.
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

4. I want medical treatments that prolong life, even if there is a loss of physical function
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

5. I want medical treatments that prolong life, even if there is a loss of mental function
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

6. I am willing to endure complications from treatments.
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

7. Medical treatments that prolong life but leave a person unable to enjoy life activities should be used.
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

8. I trust my family (or decision-maker) to make medical treatment choices for me if I am not able.
   Strongly Agree Agree Not Sure Disagree Strongly Disagree

9. Intensive care, life support measures should be continued as long as possible.
   . Strongly Agree Agree Not Sure Disagree Strongly Disagree

Name_____ DOB_____

Choices in Caring

Can you name some things that you hope to be able to enjoy for the rest of your life?

If we were to ask the person who knows you best, “What is most memorable about you?” or “What makes you special or unique?” they would say....

We hear people say "He/she no longer has any quality of life." It is important for us to understand what people mean when they say that. Are there changes in life that might leave you feeling that way? How important are each of the following to your idea of quality of life?

VI = Very Important I = Important S = Somewhat Important N = Not Important

____ Being able to talk with family and friends

____ Not being dependent on medical care

____ Being free of uncontrolled pain

____Being able to take care of myself in the morning (dressing, using the bathroom)

____ Being able to eat independently

____ Being able to learn new things

____ Being able to make my own decisions

____ Being able to run errands

Other important areas for your quality of life?

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Worksheet 1 - Values Questionnaire

The following questions can help you think about your values as they relate to medical care decisions. You may use the questions to discuss your views with your health care agent and others, or you may write answers to the questions as a help to your agent and health care team. (If you fill out this worksheet and want it to be part of your DPA/HC, sign it in the presence of witnesses and attach it to your DPA/HC form.)

1. What do you value most about your life? (For example: living a long life, living an active life, enjoying the company of family and friends, etc.)

2. How do you feel about death and dying? (Do you fear death and dying? Have you experienced the loss of a loved one? Did that person's illness or medical treatment influence your thinking about death and dying?)

3. Do you believe life should always be preserved as long as possible?

4. If not, what kinds of mental or physical conditions would make you think that life-prolonging treatment should no longer be used? Being:

    - unaware of my life and surroundings;
    - unable to appreciate and continue the important relationships in my life;
    - unable to think well enough to make every-day decisions;
    - in severe pain or discomfort;
    - other (describe)

5. Could you imagine reasons for temporarily accepting medical treatment for the conditions you have described? What might they be?

6. How much pain and risk would you be willing to accept if your chances of recovery from an illness or injury were good (50-50 or better)?

7. What if your chances of recovery were poor (less than one in 10)?

Values Questionnaire - Page 2

8. Would your approach to accepting or rejecting care depend on how old you were at the time of treatment? Why?

9. Do you hold any religious or moral views about medicine or particular medical treatments? What are they?

10. Should financial considerations influence decisions about your medical care? Explain.

11. What other beliefs or values do you hold that should be considered by those making medical care decisions for you if you become unable to speak for yourself?

12. Most people have heard of difficult end-of-life situations involving family members or neighbors or people in the news. Have you had any reactions to these situations? If so, describe:

Date:_____ Signature:_____ Date of Birth: _____

Address: _____

Witness:_____ Witness: _____

Values Checklist and Guide: My Choices Near the Ending of Life

1. Most important of all to me when thinking about end of life choices are:

___physical comfort
___family/friends present
___maintain my dignity & integrity
___other_____

___relief of pain and suffering
___to die naturally at home, if possible
___live as long as possible no matter what

2. In terms of living through serious illness and the ending of life, I define quality of life as:

___reflecting my values & beliefs
___recognizing family & friends
___having a say about care needs
___able to do things I enjoy doing
___other_____

___the ability to direct my life decisions
___making my own decisions
___maintaining my sense of independence
___receiving palliative (supportive) care & hospice

3. If I could choose where I would be when I am dying, I would want to be:

__ at home __ in the hospital __in the nursing home __other_____

4. What do you think about life-sustaining treatment? This means any medication, medical procedure or device that could be used to keep you alive when you otherwise would naturally die. This would include such things as: Cardiopulmonary resuscitation (CPR), using a breathing machine, using mechanical means to maintain blood pressure and heart rate, antibiotics, getting food or water by medical device (tube feeding), and other invasive treatments. What would you want to have in each situation below?

- If you could recover sufficiently to be comfortable and active? __use __don't use
- If you were near death with a terminal illness? __use __don't use
- If your brain's thinking function were destroyed? __use __don't use
- If you were moderately disabled by dementia e.g. Alzheimer's Disease? __use __don't use

5. What are some of the other things that are important to you?

___ nature of care should not devastate my family
___ to be pain free and comfortable
___ my spiritual care and well being
___ to be returned to my home land after I die, that being_____
___ other_____

__ my religious beliefs and traditions
__ after death care issues
__ to be in a comfortable peaceful setting

6. Which family and friends would help you with your care when you are unable to care for yourself?

7. Do your loved ones know your wishes, values and beliefs about end of life care? __yes __no

8. Have you talked to:

(a) your doctor about these issues? __ yes __ no

(b) your pastor, minister, rabbi, priest or other spiritual leader about these issues? _yes __no

If you are using this as part of your Advance Care Plan please Print Name, Sign and Date below.

Print Name:_____/Sign:_____/Date:_____

Values Checklist Provided Courtesy of:
Community Network Journey Project ©1996 707-539-2364 www.CaringCommunity.org v10/14

Other Things to Consider Concerning My End of Life Wishes

(If you do not do this part now, it is a good idea to think about these things and complete later.)

k9. I am a member of an organized church or religion? __yes __no
My specific faith, congregation or spiritual practice is_____

10. To help attend to my spiritual needs as death approaches, I would call upon:
Name(s):_____Relationship:_____Phone_____
_____

11. When I am dying I would like my surroundings as follows and I would like to have with me these special possessions:

12. As I am near to the end of my life, I would like these people informed:

13. Following my death, I would like to also inform these people:

14. I have written or will write an announcement of death (obituary): ___yes ___no

15. My wishes for after-death care are for __ natural death care __ burial ___cremation

My wishes for memorial activity are as follows:

16. If I have made arrangements, the contact person/phone is_____

17. Other things important for someone to know about me, in the event that I become incapacitated or my death is close at hand?

18. _____ _____
(your signature/date) (optional - witness signature/date)

Please attach additional sheets if needed. When completed, copy and share this with your doctor, family and caregivers and make time for meaningful conversations in the process.
It also is important to properly complete an Advance Health Care Directive (AHCD) and distribute that to people who may need to guide your care if and when you become unable to make your wishes known and honored. When completing the AHCD, we recommend that you attach to your AHCD this completed Values Checklist and Guide (or something similar) and note in AHCD under "Special Instructions:" see Values Checklist attached. Advance Health Care Directive forms are available without charge from physicians, hospitals, social service providers, care homes and others.