

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.

*NOTE: These statements are not to be construed as limitations to my Health Care Agents' authority, but are an expression of my wishes:

1. What do you most value about you 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 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 1 in 10)? _____

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 are 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: _____

Signed: _____

Date: _____ Print Name:: _____ Date of Birth: _____

Address: _____

MEDICAL SITUATIONS & THEIR TREATMENT

This worksheet presents possible treatment plans for a variety of common medical situations. You may use these examples to discuss your views with your health care agent and others, or you may write down your choices as a help to your agent and health care team.

*NOTE: These statements are not to be construed as limitations to my Health Care Agents' Authority, but are an expression of my wishes:

Possible Treatment Plans:

- A. I would want all possible efforts to preserve life as long as possible.
- B. I would want comfort care only, and would not want medical treatment, including tube-feeding, to prolong my life.
- C. I would want comfort care and tube-feeding, but would not want other types of medical treatment to prolong my life.
- D. My agent should consider the possible benefits and burdens of disease-fighting treatment, and consent only to treatment that he or she believes is in my best interests, as we have discussed them. My agent may refuse any active treatment or may consent to a trial of treatment, as we have discussed them. My agent may refuse any active treatment or may consent to a trial of treatment and then stop treatment if it is not beneficial.
- E. Treatment plan D, as described above, except that I would always want tube-feeding.

Possible Medical Situations:

1. Suppose you have a fatal ("terminal") condition. You are unconscious and death is expected soon, with or without treatment. What treatment plan would you want? (Select from above, or write your own.) _____

2. Suppose you are permanently unconscious from an accident or severe illness. There is no reasonable hope of recovering awareness, but life support could keep your body alive for years. (This is called "persistent vegetative state" or "permanent coma.") What treatment plan would you want? (Select from above, or write your own.) _____

3. Suppose you are in a state of permanent but not total confusion, perhaps from stroke or Alzheimer's disease. You are legally "incompetent" and cannot recognize or communicate with those close to you, and can do almost nothing for yourself. You could survive in this state for some time with medical treatment. What treatment plan would you want? (Select from above, or write your own.) _____

4. Suppose you are in a state of permanent but not total confusion, perhaps from stroke or Alzheimer's disease. You are legally "incompetent" and cannot recognize people and interact with them in a meaningful way, but you are up and around and people are taking care of you. You are not in distress and seem to be able to experience some satisfactions in daily life, such as in eating or hearing music. Then you get an illness that might be fatal. What treatment plan would you want? (Select from above, or write your own.) _____

5. Suppose you are frail, chronically ill and uncomfortable, with a limited range of activities available to you. Then you become unconscious, at least temporarily, due to an acute illness. The illness is likely to be fatal unless vigorously treated in a hospital, but even intensive care offers only a small chance of recovery to your former condition. It's much more likely treated in a hospital that you will end up worse off than before, or will die in spite of all heroic measures. What treatment plan would you want? (Select from above, or write your own.) _____

6. Suppose you unexpectedly suffer a serious injury or illness. You have less than a 5 percent chance of good recovery and, if you survive, will have serious brain damage. What treatment plan would you want? (Select from above, or write your own.) _____

7. Use this space to describe any other medical situations you would like to address:

Signed: _____

Date: _____ *Print Name::* _____ *Date of Birth:* _____

Address: _____