INDIANA DISABILITY RIGHTS

Advanced Directive Planning Sheet

Your name:

Your address:

Your phone number:

Your email address:

Health Care Representative

If you are unable to make or communicate your health care decisions, a health care representative (HCR) can help make those decisions for you. The questions below are designed to help you decide whether to appoint one or more HCR, who to choose, and the decisions they can make.

An HCR can:

- Say yes or no to any life support or medical treatment if you cannot do so yourself; and

Equity Through Advocacy

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This Advanced Directive Planning Sheet was funded by the Indianapolis Bar Foundation.

Decide what happens to your body after you die, such as organ donation, autopsy, and funeral plans.

Advance Directive Effective Event

When do you want your HCR to be appointed? (Please choose one.)

This question asks when you want your HCR to take effect and have your HCR appointed: right away, or only once a doctor or court decides that you can no longer make or communicate health care decisions for yourself. In either case, you still get to make health care decisions as long as you are able.

☐ Immediately after you sign the form.

☐ When a doctor or court decides you can't make decisions yourself.

☐ Effective on the following date: _____

NOTES:

Decision-Making Standards for a Health Care Representative(s)

Do you want your HCR(s) to follow your wishes or have flexibility? (Choose one.)

☐ No flexibility: My HCR(s) should follow my medical wishes as I have stated. My HCR cannot change my wishes, even if my doctors recommend it.

☐ Some flexibility: My HCR(s) can make medical decisions that differ from my previously stated wishes if my doctor recommends it. However, my HCR(s) cannot alter these specific wishes (describe below) under any circumstances:

_____

_____

_____

_____

_____

_____

_____

☐ Total flexibility: My HCR(s) can make decisions that are different from my previously stated medical decisions if my doctors recommend it.[1]

NOTES:

[1] If your HCR does not know and cannot find out your specific wishes for a medical situation that comes up, then the HCR must act in your best interests. *See* IC 16-36-7-36.

Your Continuing Right to Act and Decide Personally

How do you want to make medical decisions? (Choose one.)

☐ I want to make medical decisions by myself with or without supporters.

☐ I want to have a trusted person make medical decisions for me.

Please explain your choice.

_____

_____

_____

Important Aspects of Your Life

What people, activities, or things are most important to you? (Choose all that apply.)

Thinking about the people or things that are important to you can help you discover who in your life might be a good support. It can also help others know the value of these things in your life.

☐ My family (names(s))

_____

_____

_____

_____

☐ My friends (name(s))

_____

_____

_____

_____

☐ My pets (type(s) and name(s))

_____

_____

_____

_____

☐ My hobbies and interests

_____

_____

_____

_____

☐ Working/Volunteering:

_____

_____

_____

☐ My home:

_____

_____

_____

☐ My religion, spirituality, or faith

_____

_____

_____

_____

☐ Something else

_____

_____

_____

_____

NOTES:

Based on your current health, what would you like doctors to do if you have a life-threatening event? (Choose one.)

☐ I want all medical care necessary for me to live as long as possible.

☐ I would rather die than live with significant discomfort or permanent reliance on medical equipment.

☐ My wishes are somewhere between the two choices above. _____

_____

_____

Based on your current health, what do you consider a good quality of life?

_____

_____

_____

Based on your current health, what do you consider a poor quality of life?

_____

_____

_____

Which of the following choices would worsen your quality of life? (Choose all that apply.)

☐ Being in a coma and unable to wake up or talk to family and friends.

☐ Needing machines connected to my body to live.

☐ Not being able to remember family, friends, or important events.

☐ Needing to live in a hospital or nursing home.

☐ Having constant or severe physical discomfort.

☐ Not being able to eat or drink by mouth.

☐ Not being able to move my limbs.

☐ Not being able to communicate verbally.

☐ Something else

_____

_____

_____

_____

Why did you choose as you did? Please list any other information you want your medical providers and/or HCR(s) to know:

_____

_____

_____

_____

_____

_____

Your Wishes and Preferences About Life-Prolonging Procedures

If you were so sick or old that you were going to die soon, how would you like doctors to address a life-threatening event? (Choose one.)

☐ I want all medical care necessary for me to live as long as possible.

☐ I want to enjoy my remaining life without medical treatment.

☐ I want to be comfortable and without pain but no life-prolonging medical treatment.

☐ I want something specific depending on the circumstances.

_____

_____

_____

Your Health Care Representative(s)

Who do you want to be your HCR(s)?

HCR 1

First and last name: _____

Phone number: _____

Email address: _____

Relationship: _____

State they live in: _____

HCR 2

First and last name: _____

Phone number: _____

Email address: _____

Relationship: _____

State they live in: _____

If you have more than one HCR, how should they make decisions? (Choose one)

☐ One HCR is the main decision maker and the second is a backup if the main HCR is unable or unavailable.

- Main HCR: _____
- Backup HCR: _____

☐ My HCRs must agree with each other on each decision.

☐ Either one can make a decision independently.

NOTES:

End-of-Life Preferences

If able to choose, where would you want to die? (Choose one.)

☐ At home

☐ In the hospital

☐ Other _____

What is important to have around you when you are dying (e.g., food, music, pets, or people)?

_____

_____

_____

_____

_____

_____

If you were very likely to die soon, which life support measures would you want?

☐ All life support treatments that might help. I want treatment even if there is little hope of recovery or improvement.

☐ Life support treatments that doctors think may help. I do not want to stay on life support if it is not working and there is little hope of improvement.

☐ I do not want any life support measures, even if I die.

☐ I want the following (check all that apply):

- ☐ Food and water by mouth.
- ☐ Food and water though a feeding tube or transfusions.
- ☐ A breathing machine that can be easily taken off.
- ☐ A breathing machine that involves a tube is inside my body.
- ☐ Cardiopulmonary resuscitation (CPR).
- ☐ Dialysis.
- ☐ Other machine assistance.

☐ Blood transfusions.

☐ Antibiotics.

☐ Medication to make me comfortable.

Why did you choose as you did? Please list any other information you want your medical providers and/or HCR(s) to know about your preferences.

_____

_____

_____

_____

_____

_____

Do you want to donate your organs or body parts? (Choose one.)

☐ I want to donate any of my organs or body parts that can be used.

☐ I do not want to donate my organs or body parts.

☐ I want to donate only these specific organs and/or body parts: _____

_____

_____

_____

Do you want an autopsy performed after your death? (Choose one.)

☐ I want an autopsy.

☐ I do not want an autopsy.

☐ I only want an autopsy if there are questions about the cause of my death.

Do you have funeral or burial wishes?

I have the following religious or spiritual wishes:

_____

_____

_____

I have the following funeral or burial wishes:

_____

_____

_____

I am interested in donating my body to science:

_____

_____

_____

If you have a particular organization you would like to donate your body to (such as an institution, school, hospital, or cause) please provide this information:

Name: _____

Address: _____

Phone number: _____

Email: _____

NOTES: