End of Life Worksheet*

**This is not an official form. It is not legally or medically binding.*

Preferred Hospital: ___________________________ Doctor: ________________________________

POA

I ☐ do ☐ do not wish to appoint a medical power of attorney (POA) to make health-related decisions on my behalf in the event that I am incapacitated to the point that I am unable to make or relate my own decisions.

POA Name: ____________________________________ Relation: ____________________________

Email: ____________________________________ Phone: ____________________________

Address: ____

POA ☐ has been asked ☐ is willing ☐ is willing until/unless ________________________________

Life Support

☐ I would like to have CPR (resuscitation) attempted if I do not have a pulse/breathing
☐ I do not want to have resuscitation attempted if I do not have a pulse/breathing (DNR)

☐ I would like medical staff to perform life-saving measures on me, including medication, surgery, or life-support, unless my quality of life has decreased to any of the following parameters:

- ☐ I am in a persistent vegetative state or coma
- ☐ I am fully dependent on others for mundane care
- ☐ I am in terrible, constant pain that will not improve
- ☐ I am no longer able to communicate by any means
- ☐ I no longer recognize anyone

If my quality of life has decreased to this point, I would like only comfort/palliative care

☐ I do **NOT** want the following life-support measures to be used *(check all that apply)*:

- ☐ Feeding tube
- ☐ IV
- ☐ Breathing tube
- ☐ Antibiotics
- ☐ Painkillers
- ☐ Surgery

End of Life Care

I would prefer to receive end-of-life care ☐ at the hospital ☐ at home ☐ in hospice

I would like ☐ family ☐ friends ☐ religious officiant(s) ☐ medical staff to be in the room with me during end-of-life care and death.

☐ I would like religious end-of-life services on my deathbed from ______________________________