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HEALTH CARE VALUES HISTORY FORM

NAME: _____

DATE: _____

If someone assisted you in completing this form, please fill in his or her name, address, and relationship to you.

Name: _____
Address: _____
_____
Relationship: _____

The purpose of this form is to assist you in thinking about and writing down what is important to you about your health and medical care. If you should at some time become unable to make health care decisions for yourself, your thoughts as expressed on this form may help others make a decision for you in accordance with what you would have chosen.

The first section of this form asks whether you have already expressed your wishes concerning medical treatment through either written or oral communications and if not, whether you would like to do so now. The second section of this form provides an opportunity for you to discuss you values, wishes, and preferences in a number of different areas, such as your personal relationships, your overall attitude toward life, and your thoughts about illness.

This form is not a legal document, although is may be used as evidence of your health care values in a legal proceeding.

WHY A HEALTH CARE VALUES HISTORY FORM?

The Health Care Values History Form recognizes that health care decisions we make for ourselves are based on those beliefs, preferences and values that matter most to us: How do we feel about independence and control? About pain, illness, dying and death? What in life gives us pleasure? Sorrow? A discussion of these and other values can provide important information for those who might, in the future, have to make medical decisions for us when we are no longer able to do so.

Further, a discussion of the questions asked on the Health Care Values History Form can provide a solid basis for families, friends, physicians and others when making such health care decisions on your behalf should you become unable to do so yourself. By talking about such issues ahead of time, family disagreements may be minimized. And when such decisions do need to be made, the burden of responsibility may be lessened because others feel confident of your wishes.

HOW DO I FILL OUT THE HEALTH CARE VALUES HISTORY FORM?

Section 1 allows you to record both written and oral instructions you might already have prepared. Simply answer the questions. If you have not yet written or talked about these issues, you might wait to complete this section at a later date, perhaps after you have completed Section 2.

Section 2 asks a number of questions about issues such as: Your attitude toward your health; Your feelings about your health care providers; Your thoughts about independence and control; Personal Relationships; Your overall attitude toward life and preferences for life activities; Your attitude toward illness/dying/death; Your religious background and beliefs; Your living environment and daily routine; Your attitude toward finances.

There are a number of ways in which you might begin to answer these questions. Perhaps you would like to write out some of you own thoughts before you talk with anyone else. Or you might ask family and friends to come together and talk about your, and their, responses to the questions.

Often simply making copies of the Health Care Values History Form available to others is enough to get people talking about a subject that, for many of us, is difficult and painful to consider. The most important thing to remember is that **it is easier to talk about these issues BEFORE a health care crisis occurs.** Feel free to add questions and comments of your own to those already provided.

WHAT SHOULD I DO WITH MY COMPLETED HEALTH CARE VALUES HISTORY FORM?

Make certain that all those who might be involved in future medical decisions made on your behalf are aware of your wishes: family, friends, physicians and other health care providers, your lawyer, your Pastor. If appropriate, provide written copies to these people. But remember that each of us continues to grow and change, and so the Health Care Values History Form should be discussed and updated fairly regularly, as preferences and values evolve. Consider attaching a copy of it to your Patient Advocate Designation or Durable Power of Attorney or filing the Health Care Values History Form with your important medical papers.

WHO SHOULD CONSIDER PREPARING A HEALTH CARE VALUES HISTORY FORM?

Everyone. While it has been customary to focus on older people, it is just as important that younger people discuss these issues and make their wishes known. Often some of the most difficult medical decisions must be made on behalf of these younger patients. If they had talked with families and friends, these decision makers could feel reassured they were following the patient's wishes.

People with disabilities can also address their values as to medical care and treatment. Family members, advocates, or others can assist the person in filling out a Health Care Values History Form.

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We hope this Health Care Values History Form is of help to you, your families and friends. Many people have commented that it is important to reflect not so much on "How I want to die," but rather on **"How I want to LIVE until I die."**

Sincerely,

Beier Howlett, P.C.

SECTION 1

A. WISHES CONCERNING SPECIFIC MEDICAL PROCEDURES

If you have already expressed your wishes, either written or orally, concerning any of the following medical procedures, please complete this information. If you have not, please indicated your preferences regarding these procedures. *(Note: You may also wish to consider completing a Patient Advocate Designation, which is a legal document that allows someone you name to make decisions on your behalf in accordance with your preferences if you are unable to. Please ask us for more information!)*

Organ Donation
To whom expressed: _____
If oral, when? _____
If written, when? _____
Documentation location: _____
Comments/Preferences: _____
_____
_____
_____

Kidney Dialysis
To whom expressed: _____
If oral, when? _____
If written, when? _____
Document location: _____
Comments/Preferences: _____
_____
_____
_____

Cardiopulmonary Resuscitation (CPR)
To whom expressed: _____
If oral, when? _____
If written, when? _____
Document location: _____
Comments/Preferences: _____
_____
_____
_____

Respirators
To whom expressed: _____
If oral, when? _____
If written, when? _____

Document location: _____
Comments: _____
_____
_____

Artificial Nutrition
To whom expressed: _____
If oral, when? _____
If written, when? _____
Document location: _____
Comments: _____
_____
_____

Artificial Hydration
To whom expressed: _____
If oral, when? _____
If written, when? _____
Document location: _____
Comments: _____
_____
_____

B. GENERAL COMMENTS

Do you wish to make any general comments about the information you provided in this section?
_____
_____
_____
_____
_____
_____
_____

SECTION 2

A. YOUR OVERALL ATTITUDE TOWARD YOUR HEALTH

1. How would you describe your current health status? If you currently have any medical problems, how would you describe them? _____
_____
_____
_____

2. If you have current medical problems, in what ways, if any, do they affect your ability to function? _____
_____
_____
_____

3. How do you feel about your current health status? _____
_____
_____
_____

4. How well are you able to meet the basic necessities of life—eating, food preparation, sleeping, personal hygiene, etc.? _____
_____
_____
_____

5. Do you wish to make any general comments about your overall health? _____
_____
_____
_____
_____
_____

B. YOUR PERCEPTION OF THE ROLE OF YOUR DOCTOR AND OTHER HEALTH CAREGIVERS

1. Do you like your doctors? _____
_____

2. Do you trust your doctors? _____
_____

3. What characteristics are important to you regarding your doctors or other health care providers? What characteristics or values makes you want to change doctors or other health care providers?

_____
_____
_____
_____

4. Do you think your doctors should make the final decision concerning any treatment you might need? _____
_____
_____
_____

5. How do you relate to your caregivers, including nurses, therapists, chaplains, social workers, etc.? _____
_____
_____
_____

6. Do you wish to make any general comments about your doctor and other health caregivers, and preferences regarding medical treatment (e.g., use of minimal medications)?

_____
_____
_____
_____
_____
_____
_____

C. YOUR THOUGHTS ABOUT INDEPENDENCE AND CONTROL

1. How important is independence and self-sufficiency in your life? Are there certain areas in your life that are more important than others regarding independence and self-sufficiency (e.g., finances, employment, independent living)? _____
_____
_____
_____
_____
_____
_____

2. If you were to experience decreased physical and mental abilities, how would that affect your attitude toward independence and self-sufficiency? _____
_____
_____
_____
_____

3. Do you wish to make any general comments about the value of independence and control in your life? _____
_____
_____
_____
_____

D. YOUR PERSONAL RELATIONSHIPS

1. Do you expect that your friends, family and/or others will support your decisions regarding medical treatment you may need now or in the future? _____
_____
_____
_____
_____

2. Have you made any arrangements for your family or friends to make medical treatment decisions on your behalf? If so, who has agreed to make decisions for you and in what circumstances? _____
_____
_____
_____

3. What, if any, unfinished business from the past are you concerned about (e.g., personal and family relationships, business and legal matters)? _____
_____
_____
_____
_____

4. What role do your friends and family play in your life? _____
_____
_____
_____
_____

5. Do you wish to make any general comments about the personal relationships in your life? _
_____
_____
_____
_____

E. YOUR OVERALL ATTITUDE TOWARD LIFE AND LIFE ACTIVITIES

1. Are you happy to be alive? _____
_____
_____

2. Do you feel that life is worth living? _____
_____

3. What activities do you enjoy (e.g., hobbies, watching television)? Describe the activities in detail (e.g. type of television shows)_____
_____
_____
_____
_____

4. What type of music to you enjoy? It is an important part of your life? _____
_____
_____
_____

5. What accomplishments in your life are you most proud of?
_____
_____
_____
_____

6. How important is your current or past career path(s) to you? What do/did you do regarding employment? _____
_____
_____
_____
_____

7. How satisfied are you with what you have achieved in your life? _____
_____
_____
_____

8. What makes you laugh/cry? _____
_____
_____
_____

9. What do you fear most? What frightens or upsets you? _____
_____
_____
_____
_____

10. What goals do you have for the future?
_____
_____
_____
_____
_____

11. Do you wish to make any general comments about your attitude toward life and/or your life activities? _____
_____
_____
_____
_____

F. YOUR ATTITUDE TOWARD ILLNESS, DYING AND DEATH

1. What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)? _____
_____
_____
_____
_____

2. Where would you prefer to die? _____
_____
_____
_____

3. What is your attitude toward death? _____
_____
_____
_____

4. How do you feel about the use of life-sustaining measures in the face of :
Terminal illness? _____
_____
Permanent coma? _____
_____
Irreversible chronic illness (e.g., Alzheimer's disease)? _____
_____

5. Do you wish to make any general comments about your attitude toward illness, dying, and death? _____
_____
_____
_____
_____

G. YOUR RELIGIOUS BACKGROUND AND BELIEFS

1. What is your religious background? What is the level of your involvement in religious activities?_____
_____
_____
_____
_____

2. How do your religious beliefs affect your attitude toward serious or terminal illness?
_____
_____
_____
_____

3. Does your attitude toward death find support in your religion?_____
_____
_____
_____

4. How does your faith community, church, or synagogue view the role of prayer or religious sacraments in an illness? _____
_____
_____
_____

5. Do you wish to make any general comments about your religious background and beliefs? __
_____
_____
_____
_____
_____

H. YOUR LIVING ENVIRONMENT AND DAILY ROUTINE

1. What has been your living situation over the last 10 years (e.g., lived alone, lived with others, etc.)? What type of living situation do you prefer? _____
_____
_____
_____
_____
_____

2. How difficult is it for you to maintain the kind of environment for yourself that you find comfortable? Does any illness or medical problem you have now mean that it will be harder in the future? _____
_____
_____
_____
_____

3. Do you wish to make any general comments about your current living environment?
_____
_____
_____
_____
_____
_____

4. What is your daily routine and preferences? (e.g., early riser, night owl, activity level throughout the day, afternoon naps, bathing and hygiene schedule) You may wish to list what a typical day consists of for you regarding activities and schedule

5. Please list any values and preferences you may have regarding long-term care and future placement in more restrictive living arrangements, such as assisted living facilities and nursing homes (e.g., preferences to reside at home alone or with family members, specific continuing care facilities or nursing homes you visited and like)?

I. YOUR ATTITUDE CONCERNING FINANCES

1. How much do you worry about having enough money to provide for your care?

2. How much do you worry about providing for your children and/or other family members upon your passing?

J. OTHER PREFERENCES AND VALUES

List any other preferences or values that are important to you:

SUGGESTIONS FOR USE

After you have completed this form, you may wish to provide copies to your doctors and other health caregivers, your family, your friends, and your attorney. If you have a Patient Advocate Designation, you may wish to attach a copy of this form to those documents.

This document was drafted by Patricia E. Kefalas Dudek, Esq. and Roxanne J. Chang, Esq.
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