

VALUES CHECKLIST AND GUIDE

For Decisions Concerning My Care Through Terminal Illness Or When Otherwise Frail And Dying

For (print name and date completed): _____

1. The following items marked by an X indicate my priorities:

- | | |
|---|--|
| <input type="checkbox"/> physical comfort | <input type="checkbox"/> relief of pain and distress |
| <input type="checkbox"/> family/friends present | <input type="checkbox"/> to die naturally at home, if possible |
| <input type="checkbox"/> feeling content about life | <input type="checkbox"/> live as long as possible no matter what |
| <input type="checkbox"/> other _____ | |

2. I define quality of life as including the following indicated by an X:

- | | |
|--|--|
| <input type="checkbox"/> consistent with my values & beliefs | <input type="checkbox"/> ability to direct my life decisions |
| <input type="checkbox"/> recognizing family & friends | <input type="checkbox"/> maintaining a sense of independence |
| <input type="checkbox"/> having sufficient resources | <input type="checkbox"/> making my own decisions |
| <input type="checkbox"/> having a say about care needs | <input type="checkbox"/> receiving palliative (comfort) care & hospice |
| <input type="checkbox"/> other _____ | |

3. My caregiver preferences include:

4. Regarding the use of life-sustaining procedures (e.g. assistance with respiration, mechanical means to maintain blood pressure and heart rate, tube feeding):

- | | | |
|---|------------------------------|------------------------------------|
| If I were gravely impaired by Alzheimer’s Disease? | <input type="checkbox"/> use | <input type="checkbox"/> don’t use |
| If my brain’s thinking functions were destroyed? | <input type="checkbox"/> use | <input type="checkbox"/> don’t use |
| If I could recover sufficiently to be comfortable and active? | <input type="checkbox"/> use | <input type="checkbox"/> don’t use |
| If I were near death with a terminal illness? | <input type="checkbox"/> use | <input type="checkbox"/> don’t use |

5. I have completed items marked by an X. The notes indicate where my documents are located and who has copies or who has related authority.

- Advance Health Care Directive _____
- A Nomination of Conservatorship _____
- A Durable Power of Attorney of Finances _____
- A Will or Living Trust _____
- Non-hospital Do Not Resuscitate Form _____

___ Other papers needed for someone to manage my affairs _____

6. I am a member of an organized church or religion? ___yes ___no

My specific faith or congregation is _____

7. To help attend to my spiritual needs as death approaches, I would call upon:

Name(s): _____ Relationship: _____ Phone: _____

8. When I am dying I would like my surroundings as follows and I would like to have with me special possessions noted.

9. As death is approaching, I would like these people informed:

10. Following my death, I would like informed:

11. I would like my announcement of death (obituary) to include:

12. My wishes for after-death care and memorial activity are as follows, and if I have made arrangements, the contact person is indicated.

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

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

Notes: Complete and share this with you doctor, family and caregivers. Attach additional sheets if needed. Also, it is important to complete legal documents stating your intentions for care and who has authority to act on your behalf, when you become incapacitated. Without documents completed in a legally acceptable manner and distributed to those who should have them, life's ending could become a helpless, frustrating situation for you and others.

**Advance health care directive forms are available
without charge from physicians, hospitals and social service providers.**

www.CaringCommunity.org