# Treatment Preferences (Goals of Care)

Spectrum Health

*One of two pages. This document is a supplement to my Durable Power of Attorney for Healthcare document.*

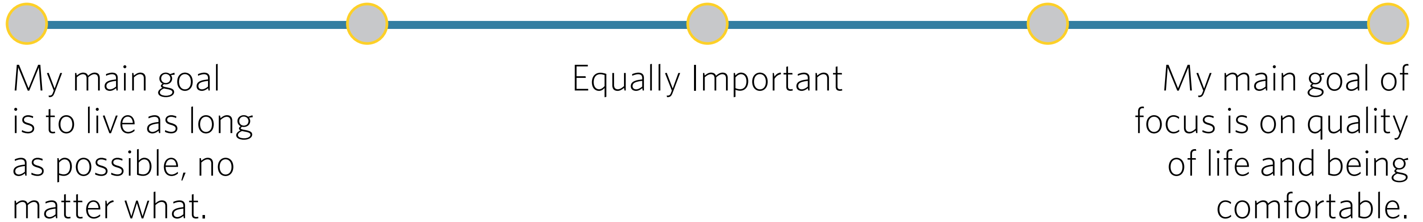
Person completing
Advance Directive (Print Name): ______________________________

Date of Birth: ____________________

The following are my specific preferences and values concerning my health care. Hopes for health:

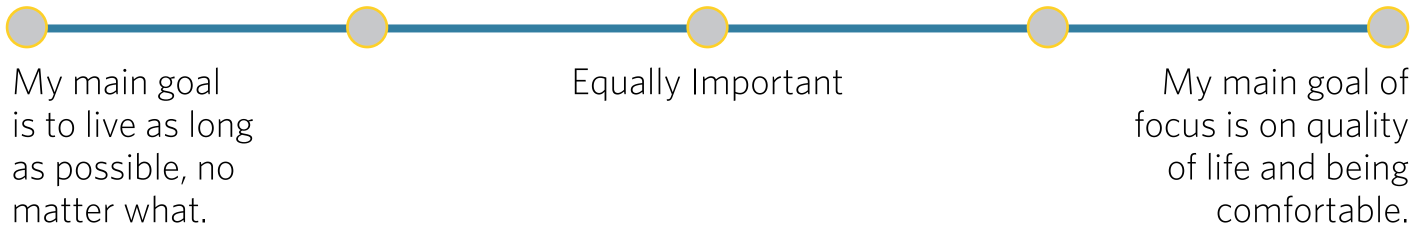
## TODAY, IN YOUR CURRENT HEALTH

**Put an X along this line to show how you feel today, in your current health.**




## AT THE END OF LIFE

**Put an X along this line to show how you feel if you were so sick <u>that you may die soon.</u>**




## Unacceptable situations (outcomes):

- ❑ Not able to wake up or talk to my family and friends
- ❑ Not being able to live without being hooked up to machines
- ❑ Not being able to think for myself, such as dementia
- ❑ Not being able to feed, bathe, or take care of myself
- ❑ Not being able to live on my own
- ❑ Having constant, severe pain or discomfort
- ❑ Something else ______________________________

## Values and experiences that are important to me:

- ❑ Communicate with my family and friends
- ❑ Activities with my family and friends
- ❑ Remain independent for as long as possible
- ❑ ______________________________
- ❑ ______________________________
- ❑ ______________________________

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Advance Directive (Print Name): ____________________________________________

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Put your initials (or "X") next to the choice you prefer for each situation below.

TREATMENT TO PROLONG LIFE

## If a circumstance arises where I am no longer able to recognize my family or friends and not expected to recover that ability:

____ I want all possible efforts to prolong life. Living as long as possible is more important than how I live.

____ I want to receive treatment and care to keep me comfortable.
How I live is more important than how long I live.

____ Undecided at this time.

## If my health worsens, and a decision needs to be made about using a ventilator:

____ I want to receive ventilator therapies to help my breathing.

____ I want to try the ventilator to help my breathing, and if I do not improve,
I would like my care to be comfort focused. I understand this may result in my death.

____ I want to receive treatment and care to keep me comfortable.
How I live is more important than how long I live.

Additional considerations: ____________________________________________

____ Undecided at this time.

## If my heart or breathing stops, my preference for Cardiopulmonary Resuscitation (CPR):

____ I want CPR

____ I do not want CPR but instead want to allow natural death.

____ Undecided at this time.

Signature :____________________________________________ Date: ______________________

*NOTE: This is not a "Do Not Resuscitate" (DNR) Order, which is a separate legal document.
Talk with your personal healthcare provider if you would like a DNR Order.*

**Patient signature** section must be **signed by hand**, it is not fillable on electronic form.
**Date** section on the can be **typed** on the fillable form.