Living Will – Advanced Health Care Directive Questionnaire

Your name: Address:
Home phone: Work phone: Cell phone:
Birth date:

Do you wish the living will to take effect ☐ now or ☐ only if you are disabled or incapacitated?
Duration of living will to be:
Do you wish to appoint a conservator? Yes ☐ No ☐ If yes, please provide name, address, and phone number:
Do you wish to be kept on artificial life support? Yes ☐ No ☐
Which of the following do you consider to be a "terminal condition":

☐ An incurable and irreversible condition that requires life support
☐ A permanent coma
☐ A persistent vegetative state

Do you want food & water administered if you are in terminal condition? Yes ☐ No ☐
Do you want any limitations on pain medication? Yes ☐ No ☐ If yes, describe:

Do you wish to donate organs? Yes ☐ No ☐
If yes, for what purpose(s)?
☐ Transplant
☐ Education
☐ Research
☐ Therapy

Who would you like to make the donation to?

☐ A particular physician: ☐ Alternate physician
☐ A medical facility:
☐ A specific donor: ☐ Alternate donor
☐ Any person or entity

What would you like to donate?

TISSUE:

☐ Eyes
☐ Bone and connective tissue

☐ Skin
☐ Heart
Other:

ORGAN:

☐ Heart
☐ Kidney(s)
☐ Liver
☐ Lung(s)
☐ Pancreas
Other:

Will you appoint an individual to make health care decisions for you? Yes ☐ No ☐
If yes:
Name of Health Care Representative: Relationship: Age:
Address of Representative:
Phone Number of Representative:
Will the Representative benefit in any way by your death (beneficiary in your will, insurance policy, etc.)? Yes ☐ No ☐ If yes, please describe:
Will you appoint an alternate individual to make health care decisions for you if the person above is unable, unavailable, or unwilling to act? Yes ☐ No ☐
If yes:
Name of alternate Health Care Representative: Relationship: Age:
Address of alternate Representative:
Phone Number of alternate Representative:
Will the alternate Representative benefit in any way by your death (beneficiary in your will, insurance policy, etc.)? Yes ☐ No ☐ If yes, please describe:

Do you wish to name a primary physician? Yes ☐ No ☐
If yes:
Physician's name: Address: Phone number:

Do you wish to name an alternate primary physician? Yes ☐ No ☐
If yes:
Physician's name: Address: Phone number:

Will personal representative be able to authorize the disposal of body remains? Yes ☐ No ☐

Will Personal Representative be able to authorize an autopsy? Yes ☐ No ☐
If there are any health care decisions you do not wish the Representative to make, please describe:
Do you wish the living will to express a desire to die at home rather than in a hospital? Yes ☐ No ☐

Do you wish the living will to express a desire to die at a hospice or other particular location rather than in a hospital? Yes ☐ No ☐ If yes, please describe;

Do you wish to express desires regarding funeral arrangements? Yes ☐ No ☐ if yes, please describe:
If you have any further health care instructions, please describe: