

Step 2—Individual Worksheet[®]

from the CRITICAL Conditions[®] Planning Guide

When you are ready to make decisions about your final health care, use this worksheet to help you think through your choices. The form can be easily removed so that you can make copies for the other members of your family. Each person should complete his or her own Individual Worksheet. Although you may want to discuss the questions with your loved ones, the completed worksheet should reflect *your* feelings and values. Your worksheet can serve as a guide to your loved ones if they ever have to make health care decisions for you. Completing this worksheet will prepare you to complete the legal document in Step 3, The Georgia Advance Directive for Health Care.

This is the Individual Worksheet of:

Name: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

Copies of this document have been given to:

1: _____
(Provide complete name, address and phone number)

2: _____
(Provide complete name, address and phone number)

3: _____
(Provide complete name, address and phone number)

4: _____
(Provide complete name, address and phone number)

Making Decisions About My Care

Refer to Conversation Starter, page 5.

1. In making decisions about my medical care, the following reflect my views:

(Check Your Responses)

- | | | | |
|---|------------------------------|-----------------------------|------------------------------------|
| a. I want to prolong my life by any means possible: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| b. I want to control pain and suffering: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| c. I want a quality of life consistent with my values: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| d. I want to keep from being a burden to my family/friends: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| e. I want to save my family's money: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| f. I want to act according to my religious beliefs: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |

My religion is: _____

2. Other things that are important to me in making these decisions are:

Defining My Quality of Life

Refer to Conversation Starter, page 4.

3. The things that make my life worth living are:

(Check Your Responses)

- | | | | |
|---|------------------------------|-----------------------------|------------------------------------|
| a. Thinking well enough to make everyday decisions: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| b. Being able to take care of myself (bathing, dressing, etc.): | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| c. Communicating with and relating to others: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| d. Being conscious and aware of what is happening around me: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| e. Being comfortable and free of pain: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| f. Living independently without aid of life-support machines: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| g. Being able to move about: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| h. Knowing my family and friends: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| i. Engaging in the following activities: | | | |

4. These things are important to me because:

Receiving Treatments If I Have an Incurable Illness

Refer to Conversation Starter, pages 6-8.

5. If I have an *incurable illness* which will *most probably cause my death*, and I can no longer speak for myself:

(Check one)

I want to try any medical treatment to prolong my life for as long as possible.

OR

I want to try medical treatments for a reasonable period of time, but I will probably want treatments other than those to control pain to be stopped if my condition does not improve.

OR

I only want pain medicine and other treatments to make me comfortable. I do not want to spend my last months having medical treatments that have no hope of curing my illness.

OR

I am undecided at this time.

6. I chose this approach because:

7. If I am in the final stages of an illness that *cannot be cured*, such as cancer, and I also have another illness that can be cured, and I can no longer speak for myself:

(Check Your Responses)

a. I want to receive medications and/or treatments for the illness that can be cured:

Yes No Undecided

b. I want any surgery necessary to treat the illness that can be cured:

Yes No Undecided

8. I made this choice because:

9. If I am in the final stages of an illness that *cannot be cured*, and that will *most probably cause my death*, and I can no longer speak for myself, I want:

Check <i>one</i> response for each treatment				
	Yes	No	Try, but if no clear improvement, stop treatment	Undecided at this time
a. A tube placed in my nose or mouth and connected to a machine to breathe for me:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
b. A tube placed in my nose or mouth, or surgically placed in my stomach, to give me food:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
c. A needle or catheter placed in my body to give me water and other fluids:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
d. Medications such as antibiotics to fight infections:				
e. Techniques used to bring a person back to life when breathing and pulse have stopped (Cardiopulmonary Resuscitation/CPR):				
f. To receive blood or blood products through a needle placed in my body (transfusions):				
g. My blood cleansed by a machine if my kidneys fail (kidney dialysis):				
h. Surgery to help prolong my life/delay my death:				
i. To receive emergency treatment if I am found unconscious in my home:				
j. To receive hospice care:				
k. Other:				

Receiving Treatments If I Have an Incurable Brain Disease

Refer to Conversation Starter, page 9.

10. If I have a *brain disease that cannot be reversed*, and I cannot recognize my family and friends, speak meaningfully to them, or live independently:

- a. I want to receive any medical treatment for the brain disease that could prolong my life:
- Yes
 - No, but I would want to receive pain medicine and other comfort care.
 - Undecided

- b. I want to be treated for any other illness that could cause my death:
- Yes
 - No, but I would want to receive pain medicine and other comfort care.
 - Undecided

11. I made these decisions because:

12. If I have a *brain disease that cannot be reversed* and I cannot recognize my family and friends, speak meaningfully to them, or live independently, I want:

Check <i>one</i> response for each treatment				
	Yes	No	Try, but if no clear improvement, stop treatment	Undecided at this time
a. A tube placed in my nose or mouth and connected to a machine to breathe for me:			(<i>check one</i>) ___ Try for a few days ___ Try for a few weeks ___ Try for a few months	
b. A tube placed in my nose or mouth, or surgically placed in my stomach, to give me food:			(<i>check one</i>) ___ Try for a few days ___ Try for a few weeks ___ Try for a few months	
c. A needle or catheter placed in my body to give me water and other fluids:			(<i>check one</i>) ___ Try for a few days ___ Try for a few weeks ___ Try for a few months	
d. Medications such as antibiotics to fight infections:				
e. Techniques used to bring a person back to life when breathing and pulse have stopped (Cardiopulmonary Resuscitation/CPR):				
f. To receive blood or blood products through a needle placed in my body (transfusions):				
g. My blood cleansed by a machine if my kidneys fail (kidney dialysis):				
h. Surgery to help prolong my life/delay my death:				
i. To receive emergency treatment if I am found unconscious in my home:				
j. Other:				

Receiving Treatments If I Am In a State of Permanent Unconsciousness

Refer to Conversation Starter, page 7.

13. If I am in a state of permanent unconsciousness and it is *highly unlikely* that I will ever wake up, I want:

	Check <i>one</i> response for each treatment			
	Yes	No	Try, but if no clear improvement, stop treatment	Undecided at this time
a. A tube placed in my nose or mouth and connected to a machine to breathe for me:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
b. A tube placed in my nose or mouth, or surgically placed in my stomach, to give me food:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
c. A needle or catheter placed in my body to give me water and other fluids:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
d. Medications such as antibiotics to fight infections:				
e. Techniques used to bring a person back to life when breathing and pulse have stopped (Cardiopulmonary Resuscitation/CPR):				
f. To receive blood or blood products through a needle placed in my body (transfusions):				
g. My blood cleansed by a machine if my kidneys fail (kidney dialysis):				
h. Surgery to help prolong my life/delay my death:				
i. Other				

Receiving Pain Medications

Refer to Conversation Starter, page 10.

14. If I have a terminal illness or injury and there is *little or no chance* that I will ever be well again, and I can no longer speak for myself, I want to receive enough medicine to relieve my pain even though:

(Check Your Responses)

- a. The drugs I am taking may cause me to be less conscious and unable to talk: Yes No Undecided

15. The reasons I have made these decisions about pain medications are:

Donating My Organs

Refer to Conversation Starter, page 11.

16. After I am dead:

(Check Your Responses)

- a. I want my organs donated to help save or improve someone else's life: Yes No Undecided
- b. I want my tissues donated to help save or improve someone else's life: Yes No Undecided
- c. I want my eyes donated to help improve someone else's life: Yes No Undecided
- d. I want my body donated for the purposes of medical education or research (Organ and tissue donation not possible with this option): Yes No Undecided

Choosing My Health Care Agent

Refer to Conversation Starter, page 13.

17. It is important that the person who makes decisions about my medical treatments when I can no longer speak for myself be someone:

(Check Your Responses)

- a. I love and trust: Yes No Undecided
- b. Who knows me very well: Yes No Undecided
- c. Who is not emotionally attached to me: Yes No Undecided
- d. Who lives near me: Yes No Undecided
- e. Who has discussed my wishes with me: Yes No Undecided
- f. Other conditions important to me are:

18. In thinking about my loved ones and the decisions I have made for my final health care, I think they will:

(Check One)

- Agree with and carry out my decisions.
- Disagree with but carry out my decisions.
- Disagree with and not carry out my decisions.
- Disagree with each other about whether or not to carry out my decisions.
- Not know what my wishes are.

19. The people I want to be my Health Care Agent and back-up Health Care Agents are:

Name(s)	Reason(s)
1st. _____	_____
2nd. _____	_____
3rd. _____	_____
4th. _____	_____
5th. _____	_____

20. When I am no longer able to speak for myself, I want my Health Care Agent to:

(Check Your Responses)

- a. Make choices for me about my medical care: Yes No Undecided
- b. Communicate my wishes to my doctor: Yes No Undecided
- c. Arrange for hospital, hospice or nursing home care for me: Yes No Undecided
- d. See any of my medical records and personal files: Yes No Undecided
- e. Apply for Medicare, Medicaid or other programs or insurance for me: Yes No Undecided
- f. Decide about the disposition of my body: Yes No Undecided
- g. Authorize an autopsy, if necessary: Yes No Undecided
- h. Discuss decisions about my care with other family members: Yes No Undecided
- i. Other:

21. When I can no longer speak for myself, I would like the following to be the final determination of what I would want:

(Check One)

- a. My preferences as I have written them down.
- b. My preferences as I have discussed them with _____.
- c. Decisions made by my Health Care Agent.
- d. Decisions made by the doctors who are treating me at the time.
- e. Other: _____.

About My Death

Refer to Conversation Starter, page 12.

22. If I have a choice, I want to die:

(Check One)

- a. in a hospital
- b. in my home
- c. in a hospice facility
- d. in a nursing home
- e. undecided at this time
- f. other: _____

23. The reasons I want to die there are:

24. When I die, I want to have these people with me, if possible:

25. My other preferences about my death include:

26. If there is a choice, I would consent to an autopsy of my body if my doctor or my Health Care Agent thinks it is necessary:

- Yes No Undecided

27. After my death I want my body to be:

(Check One:)

- a. buried b. cremated c. undecided

Signature

I completed this worksheet outlining my preferences for my final health care on the date indicated below:

Signature

Date Completed

Reviewing My Individual Worksheet

I want my family to use this Individual Worksheet as an indication of my preferences. So that they will know that it continues to reflect my feelings accurately, I have reviewed this document and confirmed my preferences by signing it again on the dates indicated below.

_____ Signature	_____ Date
_____ Signature	_____ Date
_____ Signature	_____ Date

The CRITICAL *Conditions*® Planning Guide was developed by Georgia Health Decisions, a non-profit, non-partisan organization that engages the people of Georgia in dialogue on health care issues.

