Advance Directive for End-of-Life Care

Personal Information

Full Name:

Date of Birth:

Address:

Phone:

Healthcare Agent / Proxy

Name of Healthcare Agent:

Relationship to You:

Agent's Phone:

Treatment Preferences

Life-Sustaining Treatment

☐ I do not want life-sustaining treatment if I am terminally ill or permanently unconscious

☐ I want all life-sustaining treatment possible ☐ I wish to specify treatments below

Specify treatments to withhold or provide (e.g., CPR, ventilation, artificial nutrition)...

Pain Relief

☐ I want maximum pain relief, even if it may shorten my life ☐ I wish to limit pain relief

Additional instructions about pain management...

Additional Instructions

E.g., organ donation, religious/spiritual requests, location of care, messages for loved ones...

Signatures

Signature of Principal:

Date:

Signature of Witness:

Date: