MEDICAL RECORD NUMBER:

NAME

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Treatment Preferences and Living Will

I am providing the information below to help my physicians and care team understand my care choices, particularly to help them understand my wishes relating to end-of-life care.

☐ I already have a Living will or Advance Directive that I wish to be read in conjunction with this document.

☐ I do not already have a Living Will or other Advance Directive, and would like Part 2 of this document to serve as my Living Will, and be read in conjunction with this document.

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Part 1. Information About My Treatment Preferences

If I am no longer able to make my own health decisions, the information I have provided below outlines my goals and preferences for care at the end of life.

Future health situations:

- When you think about your health and health situations you may experience in the future, how do you feel?
  - ☐ Life is always worth living no matter what type of serious illness, disability, or pain I may be experiencing.
  - ☐ There may be some health situations that would make my life not worth living.
- How do you balance quality of life with medical care? If you had serious illness, what would be important to you?
  - ☐ I want medical treatments to try to live as long as possible. I would not want to stop treatment even if I were in pain, could not feed or care for myself, or needed machines to live.
  - ☐ I want to try treatments for a period of time, but I don't want to suffer. If after a period of time the treatments do not help or I am suffering, I want to stop.
  - ☐ I want to focus on my quality of life and being comfortable, even if it means having a shorter life.

In the event of serious illness:

- If I am terminally ill or so ill that I am unlikely to get better
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am likely to die within a short period of time, and life support treatment would only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am in a coma from which I am not expected to wake up or recover, and life support treatment will only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I have permanent and severe brain damage, and I am not expected to get better, and life support treatment would only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive

Part 2. Living Will

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

As the author of this document, I request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, that the treatment options outlined below be followed. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Treatment Options at the end of life

If I have a terminal illness and am close to death or am unconscious and not likely to wake up, I want the following care:

- If my heart stops:
  - ☐ I would want cardio pulmonary resuscitation done to try to restart my heart
  - ☐ I would not want cardio pulmonary resuscitation done to try to restart my heart; if I have an implanted automatic defibrillator in place, I want to have the defibrillator turned off.

- If I'm unable to breathe on my own:
  - ☐ I would want a breathing machine
  - ☐ I would not want a breathing machine for any length of time

- If I am terminally ill or so ill that I am unlikely to get better, and I am unable to swallow enough food and water to stay alive:
  - ☐ I would want a feeding tube
  - ☐ I would not want a feeding tube

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This request is made, after careful reflection, while I am of sound mind.

Patient's Printed Name _____ Patient's Signature _____ Date _____

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Part 3 – Witnesses' Statements

WITNESSES' STATEMENTS

This document was signed in our presence by the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

First Witness

Witness Printed Name _____ Witness Signature _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Second Witness

Witness Printed Name _____ Witness Signature _____ Date _____

Address _____ City _____ State _____ Zip Code _____

(Note – this form requires two witnesses, but does not require a notary, to be valid)

INSTRUCTIONS FOR SCANNING INTO EPIC

1. Scan into Media Manager
2. For document type, select "Living Will"