My Particular Wishes for Therapies That Could Sustain Life (Advance Directive Addendum)

compassion & choices
Care and Choice at the End of Life

The following document can be added to any advance directive to provide guidance regarding consent to or refusal of certain therapies. Once completed, signed and witnessed, it should be kept with the advance directive.

This document is meant to inform my physician, nurse or other care provider of my consent to or refusal of certain specific therapies. It also guides my family or any other person I name in making healthcare decisions for me if I cannot articulate these decisions myself.

I hope this document helps those who must make difficult choices to proceed with confidence. By following these instructions they know they are acting in my best interests and are consenting or refusing certain therapies just as I would if I could hear, understand and speak.

DECISIONS WHILE I AM CAPABLE

So long as I am able to understand my condition, the nature of any proposed therapy, and the consequences of accepting or refusing the therapy, I want to make these decisions myself. I will consult my doctor, family, those close to me, spiritual advisors and others as I choose.

But the final decision is mine. If I am unable to make decisions only because I am being kept sedated, I would like the sedation lifted so I can rationally consider my situation and decide whether to accept or refuse a particular therapy.

COMFORT CARE

I want any and all therapies to maintain my comfort and dignity. If following the instructions in this document causes uncomfortable symptoms such as pain or breathlessness, I want those symptoms relieved. I desire vigorous treatment of my discomfort, even if the treatment unintentionally causes or advances the time of my death.

(please turn over)

DECISIONS FOR SPECIFIC THERAPIES

(Note: If you are unsure of the purpose of any of the following medical therapies, please speak with a health professional for clarification.)

If my mental or physical state has deteriorated, the prognosis is grave, and there is little chance that I will ever regain mental or physical function, I would like the following:

	YES	TRIAL PERIOD*	NO
1. Antibiotics if I develop a life-threatening infection of any kind.			
2. Dialysis if my kidneys cease to function, either temporarily or permanently.			
3. Artificial ventilation if I stop breathing.			
4. Electroshock if my heart stops beating.			
5. Heart-regulating drugs including electrolyte replacement if my heartbeat becomes irregular.			
6. Cortisone or other steroid therapy if tissue swelling threatens vital centers in my brain.			
7. Stimulants, diuretics or any other treatment for heart failure if the strength and function of my heart is impaired.			
8. Blood, plasma or replacement fluids if I bleed or lose fluid circulating in my body.			
9. Artificial nutrition.			
10. Artificial hydration.			

** Doctors may see whether the therapy quickly reverses my condition. If it does not, I want it discontinued.*

Signature *(Please print this document and sign with a pen.)* Date

Witness Signature *(Please print this document and sign with a pen.)* Date

This document is not intended as legal advice. Your state may have specific laws about how this document should be completed. Consult local counsel for advice specific to your situation.