# The Law Office of Michael J. Girardi

#### Advanced Healthcare Directive Questionnaire

## THE PERSONAL AND CONFIDENTIAL FILE OF

If you have any questions or need assistance in completing this questionnaire, please do not hesitate to call 724-339-1062. Make sure to complete this questionnaire and bring it with you to our initial meeting.

### ALL THE INFORMATION YOU PROVIDE IN THIS QUESTIONNAIRE IS <u>STRICTLY</u> CONFIDENTIAL.

PLEASE NOTE that no attorney-client relationship has been formed by receiving or completing this questionnaire. If you do not return your completed questionnaire within <u>THIRTY (30) DAYS</u> from the date of receipt, your file will be closed and the Law Office of Michael J. Girardi will take no further actions in this matter.

#### INTRODUCTION

Pennsylvania law gives you the right to direct and control the health care treatment you receive. While you are physically and mentally well enough to personally direct your own care, you will be in complete charge of the treatments provided to you. Once you become unable to understand the medical information provided to you, reach a decision, or communicate the decision to others, an Advanced Healthcare Directive, comprised of a health care power of attorney and living will, will allow you to continue to have control over your care and treatment.

This questionnaire is consists of three parts:

<u>Part I – Health Care Power of Attorney Agents</u> – Designate the individual(s) you want to make health care decisions on your behalf if you are unable to do so.

<u>Part II – Health Care Treatment Instructions</u> - Four situations are presented, each with several treatment and/or care options. Please review each situation and indicate your preferred options. Your stated preferences will be used to create your Advanced Healthcare Directive and will guide or direct your health care agent when he or she must make health care decisions for you.

<u>Part III – Anatomical Gifts</u> – Articulate if you desire to make anatomical gifts, whether for medical study or transplant, subject to any particular limitations or circumstances.

Please keep in mind that no document, no matter how well drafted, is a substitute for thoughtful, informed medical decision making grounded upon conversations between you and your doctor, your doctor and your healthcare agent, and MOST IMPORTANTLY, between you and healthcare agent, BEFORE the loss of capacity.

#### PART I - HEALTH CARE POWER OF ATTORNEY AGENTS

The agent under a health care power of attorney has the power to make decisions on your on a variety of health related issues when you are incapacitated. A good agent is honest and loyal, understands your goals and beliefs regarding end-of-life care, does not live far away, and is mentally and physically capable of acting on your behalf when you are unwilling or unable. A secondary agent should be named as a back-up in case the primary agent is unwilling or unable to serve.

Designate your primary agent, and at least one alternate agent. Include contact information for each.

Primary Agent				
Name:				
Relation to You:	 			
Address:	 			
City / State / Zip:	 	/	/	
Home Phone:	 			
Cell Phone:	 			
Email:				
First Alternative Age Name:				
Relation to You:				
Address:	 			
City / State / Zip:		/	/	
Home Phone:	 			
Cell Phone:	 			
Email:				

Second Alternative Agent			
Name:			
Relation to You:			
Address:			
City / State / Zip:	/	/	
Home Phone:			
Cell Phone:			
Email:			
Third Alternative Agent Name:			
Λ d d mass.			
City / State / Zip:	/	/	
II. DI.			
Cell Phone:			
Email:			

Do NOT put me on dialysis

Put me on dialysis for a trial period. End dialysis if my condition does not

to

Kidney Dialysis

improve.

Put me on dialysis

4.

#### PART II – HEALTH CARE TREATMENT INSTRUCTIONS

#### SITUATION ONE

	If I am in a coma or in a persistent		Let my Agent decide
veget	ative state, and if after a period of at least		
three	months two physicians agree that I will	5.	Diagnostic Tests
never	again be able to think or recognize		Perform necessary diagnostic test
anyoi	ne or do even simple things like eating,		Do NOT perform diagnostic tests
walki	ng, or caring for my own hygiene, then I		Only perform if they are necessary
direct	t the following:		determine the cause of my pain.
			Let my Agent decide
1.	Cardiopulmonary Resuscitation		
	(CPR)	6.	Minor Surgery
	Perform		Perform necessary minor surgery
	Do <b>NOT</b> perform		Do NOT perform minor surgery
	Let my Agent decide		Only perform if it is necessary to
			determine the cause of my pain.
2.	Mechanical Breathing		Let my Agent decide
If, aft	er diagnosis, I require medical assistance		
with	breathing:	7.	Major Surgery
	Connect me to a respirator		Perform necessary major surgery
	Do NOT connect met to a respirator		Do NOT perform major surgery
	Connect me for a trial period. Remove		Only perform if it is necessary to
	me if my condition does not improve.		determine the cause of my pain.
	Let my Agent decide		Let my Agent decide
3.	Tube Feeding		
	I want to be tube-fed		
	I do <b>NOT</b> want to be tube-fed		
	Tube-fed me for a trial period. End if	Situat	tion One is continued on the next page
	my condition does not improve.		1 0
	Let my Agent decide		

8.	Chemotherapy	Additional Comments:
	I want chemotherapy	If you want to add any further instructions or
	I do NOT want chemotherapy	clarifications regarding Situation One, please
	Perform chemotherapy for a trial	use the space provided here.
	period. End if my condition does not	
	improve.	
	Let my Agent decide	
9.	Blood Transfusion	
	I want to receive blood transfusions	
	I do NOT want to receive blood	
	transfusions	
	I want blood transfusions for a trial	
	period. End if my condition does not	
	improve.	
	Let my Agent decide	
10.	Antibiotics	SITUATION TWO
	I want to receive antibiotics	
	I do NOT want to receive antibiotics	If I have sustained a head injury
	I want to receive antibiotics for a trial	and/or am in a coma with physicians in
	period. End if my condition does not	agreement that the extent of the damage is
	improve.	unknown and the long-range outcome is
	Let my Agent decide	unpredictable, then I direct the following:
11.	Pain Medication and Comfort Care	1. Cardiopulmonary Resuscitation
	If I am in pain, I want to receive	(CPR)
	enough medication to stop the pain.	Perform
	I do NOT want to receive pain	Do <b>NOT</b> perform
	medication	Let my Agent decide
	Let my Agent decide	
	I want to be kept clean, turned	Situation Two is continued on the next page
frequ	ently, and receive whatever other care is	
neces	sary to maintain my dignity.	

2.	Mechanical Breathing	6.	Minor Surgery
If, af	ter diagnosis, I require medical assistance		Perform necessary minor surgery
with	breathing:		Do NOT perform minor surgery
	Connect me to a respirator		Only perform if it is necessary to
	Do NOT connect met to a respirator		determine the cause of my pain.
	Connect me for a trial period. Remove		Let my Agent decide
	me if my condition does not improve.		
	Let my Agent decide	7.	Major Surgery
			Perform necessary major surgery
3.	Tube Feeding		Do NOT perform major surgery
	I want to be tube-fed		Only perform if it is necessary to
	I do <b>NOT</b> want to be tube-fed		determine the cause of my pain.
	Tube-fed me for a trial period. End if		Let my Agent decide
	my condition does not improve.		
	Let my Agent decide	8.	Chemotherapy
			I want chemotherapy
4.	Kidney Dialysis		I do NOT want chemotherapy
	Put me on dialysis		Perform chemotherapy for a trial
	Do NOT put me on dialysis		period. End if my condition does not
	Put me on dialysis for a trial period.		improve.
	End dialysis if my condition does not		Let my Agent decide
	improve.		
	Let my Agent decide	9.	Blood Transfusion
			I want to receive blood transfusions
5.	Diagnostic Tests		I do NOT want to receive blood
	Perform necessary diagnostic test		transfusions
	Do NOT perform diagnostic tests		I want blood transfusions for a trial
	Only perform if they are necessary to		period. End if my condition does not
	determine the cause of my pain.		improve.
	Let my Agent decide		Let my Agent decide

Situation Two is continued on the next page

10.	Antibiotics I want to receive antibiotics	SITUATION THREE
	I do NOT want to receive antibiotics I want to receive antibiotics for a trial period. End if my condition does not improve. Let my Agent decide	If I am suffering from a degenerative brain disease, such as Alzheimer's, and I have deteriorated to the point where I am no longe able to understand things or make decisions, AND I ALSO DEVELOP A TERMINAL ILLNESS, then I direct the following:
11.	Pain Medication and Comfort Care If I am in pain, I want to receive enough medication to stop the pain. I do NOT want to receive pain medication Let my Agent decide	<ol> <li>Cardiopulmonary Resuscitation         (CPR)         Perform         Do NOT perform         Let my Agent decide</li> </ol>
	I want to be kept clean, turned ently, and receive whatever other care is sary to maintain my dignity.	<ol> <li>Mechanical Breathing</li> <li>If, after diagnosis, I require medical assistance with breathing:         <ul> <li>Connect me to a respirator</li> <li>Do NOT connect met to a respirator</li> <li>Connect me for a trial period. Remove</li> </ul> </li> </ol>
If you	tional Comments:  1 want to add any further instructions or ications regarding Situation Two, please	me if my condition does not improve.  Let my Agent decide
	ne space provided here.	<ul> <li>3. Tube Feeding</li> <li>I want to be tube-fed</li> <li>I do NOT want to be tube-fed</li> <li>Tube-fed me for a trial period. End if my condition does not improve.</li> <li>Let my Agent decide</li> </ul>
		Situation Three is continued on the next page

4.	Kidney Dialysis	9. Blood Transfusion	
	Put me on dialysis	I want to receive blood transf	usions
	Do NOT put me on dialysis	I do NOT want to receive blo	boc
	Put me on dialysis for a trial period.	transfusions	
	End dialysis if my condition does not	I want blood transfusions for	a trial
	improve.	period. End if my condition of	does not
	Let my Agent decide	improve.	
		Let my Agent decide	
5.	Diagnostic Tests		
	Perform necessary diagnostic test	10. Antibiotics	
	Do NOT perform diagnostic tests	I want to receive antibiotics	
	Only perform if they are necessary to	I do NOT want to receive an	tibiotics
	determine the cause of my pain.	I want to receive antibiotics for	or a trial
	Let my Agent decide	period. End if my condition o	does not
		improve.	
6.	Minor Surgery	Let my Agent decide	
	Perform necessary minor surgery		
	Do NOT perform minor surgery	11. Pain Medication and Comf	ort Care
	Only perform if it is necessary to	If I am in pain, I want to rece	eive
	determine the cause of my pain.	enough medication to stop th	ne pain.
	Let my Agent decide	I do NOT want to receive pa	in
		medication	
7.	Major Surgery	Let my Agent decide	
	Perform necessary major surgery		
	Do NOT perform major surgery	I want to be kept clean, turne	ed
	Only perform if it is necessary to	frequently, and receive whatever other	er care is
	determine the cause of my pain.	necessary to maintain my dignity.	
	Let my Agent decide		
8.	Chemotherapy		
	I want chemotherapy		
	I do NOT want chemotherapy	Situation Three is continued on the nex	xt page
	Perform for a trial period. End if my		1 0
	condition does not improve.		
	Let my Agent decide		

Situation Four is continued on the next page

Additional Comments:	2. Mechanical Breathing		
If you want to add any further instructions or	If, after diagnosis, I require medical assistance		
clarifications regarding Situation Three, please	with breathing:		
use the space provided here.	Connect me to a respirator		
	Do NOT connect met to a respirator		
	Connect me for a trial period. Remove		
	me if my condition does not improve.		
	Let my Agent decide		
	3. Tube Feeding		
	I want to be tube-fed		
	I do <b>NOT</b> want to be tube-fed		
	Tube-fed me for a trial period. End if		
	my condition does not improve.		
	Let my Agent decide		
SITUATION FOUR	4. Kidney Dialysis		
	Put me on dialysis		
If I am suffering from a degenerative	Do NOT put me on dialysis		
brain disease, such as Alzheimer's, and I have	Put me on dialysis for a trial period.		
deteriorated to the point where I am no longer	End dialysis if my condition does not		
able to understand things or make decisions,	improve.		
BUT I DO NOT HAVE A TERMINAL	Let my Agent decide		
ILLNESS, then I direct the following:			
	5. Diagnostic Tests		
1. Cardiopulmonary Resuscitation	Perform necessary diagnostic test		
(CPR)	Do NOT perform diagnostic tests		
Perform	Only perform if they are necessary to		
Do <b>NOT</b> perform	determine the cause of my pain.		
Let my Agent decide	Let my Agent decide		

6.	Minor Surgery	I want to receive antibiotics for a trial
	Perform necessary minor surgery	period. End if my condition does not
	Do NOT perform minor surgery	improve.
	Only perform if it is necessary to	Let my Agent decide
	determine the cause of my pain.	
	Let my Agent decide	11. Pain Medication and Comfort Care
		If I am in pain, I want to receive
7.	Major Surgery	enough medication to stop the pain.
	Perform necessary major surgery	I do NOT want to receive pain
	Do NOT perform major surgery	medication
	Only perform if it is necessary to	Let my Agent decide
	determine the cause of my pain.	
	Let my Agent decide	I want to be kept clean, turned
		frequently, and receive whatever other care is
8.	Chemotherapy	necessary to maintain my dignity.
	I want chemotherapy	
	I do NOT want chemotherapy	
	Perform chemotherapy for a trial	Additional Comments:
	period. End if my condition does not	If you want to add any further instructions or
	improve.	clarifications regarding Situation Four, please
	Let my Agent decide	use the space provided here.
9.	Blood Transfusion	
	I want to receive blood transfusions	
	I do NOT want to receive blood	
	transfusions	
	I want blood transfusions for a trial	
	period. End if my condition does not	
	improve.	
	Let my Agent decide	
10.	Antibiotics	
	I want to receive antibiotics	
	I do NOT want to receive antibiotics	

#### **AUTHORITY OF INSTRUCTIONS OVER AGENT**

You have the choice to either: (1) require your agent be bound to the instructions contained

After you have carefully considered what medical treatments you would want to accept or reject if you were in any of the four situations described above, it is important that you and your selected health care agents discuss these options and the reasons behind your decision (personal, religious, ethical, moral, etc.).

#### PART III – ANATOMICAL GIFTS

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Do you consent to donate your organs, tissues, or any other part or all of your body at the time of
your death? Yes No
If yes, please check all that apply:
I consent to the donation for BOTH medical study and transplants.
I consent to the donation ONLY for medical study.
I consent to the donation ONLY for transplants.
I consent to the donation ONLI for transplants.
I consent to the donation subject to the following limitations:
Certification
The undersigned hereby represent to the Law Office of Michael J. Girardi that the
information contained in this questionnaire is accurate and complete, and that the
undersigned understand that the Law Office will rely on this information. I understand that
if the information contained herein is inaccurate or incomplete, the recommendations made
by the Law Office may not be appropriate.
Date