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 STRICTLY 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 **THIRTY (30) DAYS** 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:

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

Part II – Health Care Treatment Instructions - 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.

Part III – Anatomical Gifts – 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 Agent

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: _____

Relation to You: _____

Address: _____

City / State / Zip: _____ / _____ / _____

Home Phone: _____

Cell Phone: _____

Email: _____

PART II – HEALTH CARE TREATMENT INSTRUCTIONS

SITUATION ONE

If I am in a coma or in a persistent vegetative state, and if after a period of at least three months two physicians agree that I will never again be able to think or recognize anyone or do even simple things like eating, walking, or caring for my own hygiene, then I direct the following:

1. **Cardiopulmonary Resuscitation (CPR)**

____ Perform
____ Do **NOT** perform
____ Let my Agent decide

2. **Mechanical Breathing**

If, after diagnosis, I require medical assistance with breathing:

____ 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 **NOT** want to be tube-fed
____ Tube-fed me for a trial period. End if my condition does not improve.
____ Let my Agent decide

4. **Kidney Dialysis**

____ Put me on dialysis
____ Do NOT put me on dialysis
____ Put me on dialysis for a trial period. End dialysis if my condition does not improve.
____ Let my Agent decide

5. **Diagnostic Tests**

____ Perform necessary diagnostic test
____ Do NOT perform diagnostic tests
____ Only perform if they are necessary to determine the cause of my pain.
____ Let my Agent decide

6. **Minor Surgery**

____ Perform necessary minor surgery
____ Do NOT perform minor surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

7. **Major Surgery**

____ Perform necessary major surgery
____ Do NOT perform major surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

Situation One is continued on the next page

8. **Chemotherapy**

____ I want chemotherapy
____ I do NOT want chemotherapy
____ Perform chemotherapy for a trial 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**

____ I want to receive antibiotics
____ 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

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

____ I want to be kept clean, turned frequently, and receive whatever other care is necessary to maintain my dignity.

Additional Comments:

If you want to add any further instructions or clarifications regarding Situation One, please use the space provided here.

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SITUATION TWO

If I have sustained a head injury and/or am in a coma with physicians in agreement that the extent of the damage is unknown and the long-range outcome is unpredictable, then I direct the following:

1. **Cardiopulmonary Resuscitation (CPR)**

____ Perform
____ Do **NOT** perform
____ Let my Agent decide

Situation Two is continued on the next page

2. **Mechanical Breathing**

If, after diagnosis, I require medical assistance with breathing:

____ 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 **NOT** want to be tube-fed
____ Tube-fed me for a trial period. End if my condition does not improve.
____ Let my Agent decide

4. **Kidney Dialysis**

____ Put me on dialysis
____ Do NOT put me on dialysis
____ Put me on dialysis for a trial period. End dialysis if my condition does not improve.
____ Let my Agent decide

5. **Diagnostic Tests**

____ Perform necessary diagnostic test
____ Do NOT perform diagnostic tests
____ Only perform if they are necessary to determine the cause of my pain.
____ Let my Agent decide

6. **Minor Surgery**

____ Perform necessary minor surgery
____ Do NOT perform minor surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

7. **Major Surgery**

____ Perform necessary major surgery
____ Do NOT perform major surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

8. **Chemotherapy**

____ I want chemotherapy
____ I do NOT want chemotherapy
____ Perform chemotherapy for a trial 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

Situation Two is continued on the next page

10. **Antibiotics**

____ I want to receive antibiotics
____ 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

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

____ I want to be kept clean, turned frequently, and receive whatever other care is necessary to maintain my dignity.

Additional Comments:

If you want to add any further instructions or clarifications regarding Situation Two, please use the space provided here.

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SITUATION THREE

If I am suffering from a degenerative brain disease, such as Alzheimer's, and I have deteriorated to the point where I am no longer able to understand things or make decisions, AND I ALSO DEVELOP A TERMINAL ILLNESS, then I direct the following:

1. **Cardiopulmonary Resuscitation (CPR)**

____ Perform
____ Do **NOT** perform
____ Let my Agent decide

2. **Mechanical Breathing**

If, after diagnosis, I require medical assistance with breathing:

____ 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 **NOT** want to be tube-fed
____ Tube-fed me for a trial period. End if my condition does not improve.
____ Let my Agent decide

Situation Three is continued on the next page

4. **Kidney Dialysis**

____ Put me on dialysis
____ Do NOT put me on dialysis
____ Put me on dialysis for a trial period. End dialysis if my condition does not improve.
____ Let my Agent decide

5. **Diagnostic Tests**

____ Perform necessary diagnostic test
____ Do NOT perform diagnostic tests
____ Only perform if they are necessary to determine the cause of my pain.
____ Let my Agent decide

6. **Minor Surgery**

____ Perform necessary minor surgery
____ Do NOT perform minor surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

7. **Major Surgery**

____ Perform necessary major surgery
____ Do NOT perform major surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

8. **Chemotherapy**

____ I want chemotherapy
____ I do NOT want chemotherapy
____ Perform for a trial 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**

____ I want to receive antibiotics
____ 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

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

____ I want to be kept clean, turned frequently, and receive whatever other care is necessary to maintain my dignity.

Situation Three is continued on the next page

Additional Comments:

If you want to add any further instructions or clarifications regarding Situation Three, please use the space provided here.

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SITUATION FOUR

If I am suffering from a degenerative brain disease, such as Alzheimer's, and I have deteriorated to the point where I am no longer able to understand things or make decisions, BUT I DO NOT HAVE A TERMINAL ILLNESS, then I direct the following:

1. **Cardiopulmonary Resuscitation (CPR)**

____ Perform
____ Do **NOT** perform
____ Let my Agent decide

2. **Mechanical Breathing**

If, after diagnosis, I require medical assistance with breathing:

____ 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 **NOT** want to be tube-fed
____ Tube-fed me for a trial period. End if my condition does not improve.
____ Let my Agent decide

4. **Kidney Dialysis**

____ Put me on dialysis
____ Do NOT put me on dialysis
____ Put me on dialysis for a trial period. End dialysis if my condition does not improve.
____ Let my Agent decide

5. **Diagnostic Tests**

____ Perform necessary diagnostic test
____ Do NOT perform diagnostic tests
____ Only perform if they are necessary to determine the cause of my pain.
____ Let my Agent decide

Situation Four is continued on the next page

6. **Minor Surgery**

____ Perform necessary minor surgery
____ Do NOT perform minor surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

7. **Major Surgery**

____ Perform necessary major surgery
____ Do NOT perform major surgery
____ Only perform if it is necessary to determine the cause of my pain.
____ Let my Agent decide

8. **Chemotherapy**

____ I want chemotherapy
____ I do NOT want chemotherapy
____ Perform chemotherapy for a trial 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**

____ I want to receive antibiotics
____ 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

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

____ I want to be kept clean, turned frequently, and receive whatever other care is necessary to maintain my dignity.

Additional Comments:

If you want to add any further instructions or clarifications regarding Situation Four, please use the space provided here.

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AUTHORITY OF INSTRUCTIONS OVER AGENT

You have the choice to either: (1) require your agent be bound to the instructions contained within your Advanced Healthcare Directive; or (2) allow your agent to use the instructions as guidance and potentially override your instructions, subject to any specific limitations. Please indicate your preference:

_____ My health care agent MUST FOLLOW these instructions.

Or

_____ My health care agent may treat these instructions as only guidance, and shall have the final say and may override my instructions, subject to the following limitations:

_____
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_____

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

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 subject to the following limitations:

_____
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_____

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