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 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 me 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.

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 me 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 tests  
___ 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 me 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 tests
   - [ ] 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 me 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:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

### 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