SUPPLEMENTAL INFORMATION ABOUT MY HEALTHCARE AND TREATMENT PREFERENCES (Page 1 of 2)

I, ____ , on this date ______________________________ would like to provide the following supplemental information to my surrogate decision-maker(s) (my "Attorney-in-Fact"), my doctor and other my healthcare providers, and ask that this information be considered when making healthcare and treatment decisions on my behalf. I understand they will do their best to comply with this information to the extent they are technically, ethically and legally able; and as long as such decisions do not risk causing harm to myself or others.

General information I would like you to know about me:

Information about symptom management and pain control: *(i.e. my definition of adequate pain management; balance between alertness and pain/symptom control; things I find helpful for treating my pain and other symptoms)*

Information about food and nutrition: *(i.e. foods and drinks I like, my preferences about medically assisted nutrition and hydration, or "tube feeding")*

Information about other healthcare and treatment preferences: *(i.e. complimentary therapies such as massage, aroma therapy, or meditation)*

Information about where I would like to receive care for my healthcare and treatment needs, including care at the end of my life: *(i.e. at home, in a hospital, in a specific care facility, by a hospice team)*

Person completing this form initial ________ Date: ________

SUPPLEMENTAL INFORMATION ABOUT MY HEALTHCARE AND TREATMENT PREFERENCES (Page 2 of 2)

Information about life-sustaining treatments that may prolong the dying process: *(i.e. long-term ventilator support to help me breathe, antibiotics to treat infections such as pneumonia)*

Things that bring me comfort *(i.e. prayers or religious readings that I like, pictures of loved ones, a special blanket or piece of clothing, favorite music or stories, people and things I would like surrounding me)*

Specific instructions about:
Organ, Tissue, Eye and Body Donation:

Autopsy Preferences:

Burial or Cremation Preferences:

Funeral Arrangements/Memorial Service:

I recognize that it is important to discuss the information in this document with the people who will be involved in making decisions related to my healthcare and treatment needs if I cannot make decisions for myself. Because of that, *(check any of the following that apply):*

I have discussed this information with my surrogate decision-maker(s):

I have discussed this information with the following doctors and other healthcare providers:

I have discussed this information with the following people *(i.e. other family members, friends, or emergency contacts who may be present as healthcare and treatment decisions are made on my behalf):*

Be sure to attach copies of this supplemental information form to your Advance Directives documents and provide copies of this supplemental information to your doctor, surrogate decision-maker(s) and other healthcare providers.

Person completing this form initial ________ Date: ________