HEALTH CARE DIRECTIVE

Declaration made this _____ day of _____, 20_____.

I, _____, (DOB) _____, want everyone who cares for me to know what healthcare I want.

An acceptable quality of life to me is one that includes the following capacities and values.

□ recognize family or friends □ make decisions □ communicate
□ feed myself □ take care of myself □ be responsive to my environment
Other _____

□ I want my doctor to try treatments on a time-limited basis when the goal is to restore my health or help me experience a life in a way consistent with my values and wishes. I want such treatments withdrawn when they cannot achieve this goal or become too burdensome to me.

Among the time-limited treatments I would **NOT** agree to under any circumstances are:

□ resuscitation (CPR) □ dialysis □ ventilator
□ food or water by tube □ chemotherapy □ transfusions
□ antibiotics □ surgery
Other _____

□ I always expect to be given care and treatment for pain or discomfort even if such care may affect how I sleep, eat, or breathe.

□ I want my dying to be as natural as possible. Therefore, I direct that no treatment (including food or water by tube) be given just to keep my body functioning when I have a condition that will cause me to die soon, or a condition so bad that I have no reasonable hope of achieving a quality of life that is acceptable to me.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

I intend for this to be my direction to my physician(s), other healthcare providers, my family and all others.

Signature: _____ Date: _____

Location: _____, _____, Kansas
(city) (county)