

Power of Attorney for PERSONAL CARE

Your Power of Attorney for Personal Care allows you to set out your wishes regarding refusal or consent to specific treatments and personal care.

Please refer below to clauses that you should consider inserting into your Power of Attorney for Personal Care.

Kindly indicate which clause below that you would like to have inserted into your Power of Attorney for Personal Care. If you wish to use clause 2, kindly check off your consent or refusal of each specific treatment choice that apply to you.

1. **If I am terminally ill or in a vegetative state, I do not wish to use life prolonging measures that will only delay the inevitable occurrence of my death. To me, an early, easy death is preferable to extra months of life so filled with deterioration, dependence and demeaning pain and suffering that they are not really life.**

I would like to have this clause inserted into my Power of Attorney for Personal Care

Yes No

OR

2. **If I am suffering from a terminal condition, or become permanently unconscious, or am in a persistent vegetative state, I want only treatment that will keep me as comfortable and as free from pain as possible. In particular (*check only those that apply to you; if you are aware of other specific treatment choices that are relevant to you, please add them to the list*):**

IF I AM IN A TERMINAL CONDITION:

I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want cardiac resuscitation
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want mechanical respiration
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want nutrition (food) or hydration (water) by tubes
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want blood or blood products
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want surgery or invasive test
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want antibiotics

IF I AM PERMANENTLY UNCONSCIOUS:

I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want cardiac resuscitation
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want mechanical respiration
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want nutrition (food) or hydration (water) by tubes
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want blood or blood products
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want surgery or invasive tests
I DO	<input type="checkbox"/>	I DO NOT	<input type="checkbox"/>	want antibiotics

IF I AM IN A PERSISTENT VEGETATIVE CONDITION:

- | | | | | |
|------|--------------------------|----------|--------------------------|--|
| I DO | <input type="checkbox"/> | I DO NOT | <input type="checkbox"/> | want cardiac resuscitation |
| I DO | <input type="checkbox"/> | I DO NOT | <input type="checkbox"/> | want mechanical respiration |
| I DO | <input type="checkbox"/> | I DO NOT | <input type="checkbox"/> | want nutrition (food) or hydration (water) |
| I DO | <input type="checkbox"/> | I DO NOT | <input type="checkbox"/> | want blood or blood products |
| I DO | <input type="checkbox"/> | I DO NOT | <input type="checkbox"/> | want surgery or invasive tests |
| I DO | <input type="checkbox"/> | I DO NOT | <input type="checkbox"/> | want antibiotics |

I would like to have this clause inserted into my Power of Attorney for Personal Care

Yes No