Personal Wishes Statement

This form is an expression of my wishes and is not legally binding.

I, _____, sign this form for the purpose of offering my Health Care Agent guidance so that he or she may make decisions based on an assessment of my personal wishes as well as medical information provided by my physicians. My Health Care Agent has authority to make such decisions in accordance with Massachusetts law.

If there is no reasonable expectation for my recovery and, in the opinion of my physician, I will die without life sustaining treatment that only prolongs the dying process, I ask that my Health Care Agent consider the following:
(Write your initials next to the lines that express your wishes.)

_____ Treatment should be given to maintain my dignity, keep me comfortable and relieve pain.
_____ If my heart stops, I do not want it to be restarted.
_____ If I stop breathing, I do not want to have a breathing tube put into my throat and be hooked up to a breathing machine.
_____ My physician may withdraw or withhold treatment that only serves to prolong the dying process. Treatment that may be withheld shall include, but not be limited to, the following:

_____If I cannot drink, I do not want to receive fluids through a needle placed in my vein.
_____If I cannot swallow, I do not want a tube inserted in my nose, mouth or surgically placed to give me food or fluids.
_____If I have an infection, I do not want antibiotics administered to prolong my life, without hope of cure, unless necessary to keep me comfortable.

_____ If possible, I would like to die at home with hospice care or in a hospice residence.
_____If I am in a nursing home I would like to die with hospice care.
_____Unless necessary for my comfort, I would prefer NOT to be hospitalized.

_____My faith tradition is _____
My spiritual contact person is _____
My faith community is _____
_____I wish to have spiritual support.

_____If possible, I wish to be an organ/tissue donor.

_____Following is additional guidance for my Health Care Agent's consideration:
_____
_____
_____
_____

Signature: _____ Date: _____