TUSHAUS WEALTH MANAGEMENT

QUALITY OF LIFE DIRECTIVE

Scottsdale Office
9845 East Bell Road, Suite 120
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My Health Care Goals

MY HEALTH CARE GOALS

Read each statement below, then rate how important each of these health care goals is to you on a scale of "0" (not important at all) to "4" (extremely important).

Importance of pain control:	**Not Important**				**Important**
Being as comfortable and free from pain as possible.	0	1	2	3	4
Having pain controlled, even if my ability to think clearly is reduced.	0	1	2	3	4
Having pain controlled, even if it shortens my life.	0	1	2	3	4

Importance of the use of life-prolonging treatment when:					
I have a better than 50% chance of recovering both physically and mentally.	0	1	2	3	4
I have some physical limitations but can socially relate to those I care about.	0	1	2	3	4
I can live a longer life no matter what my physical or mental health.	0	1	2	3	4
I have little or no chance of doing everyday activities I enjoy.	0	1	2	3	4
I am not able to socially relate to those I care about.	0	1	2	3	4
I have severe and permanent brain injury and little chance of regaining consciousness.	0	1	2	3	4
I have severe dementia or confusion and my condition will only get worse.	0	1	2	3	4

Importance of finances and health care:					
Having my wishes followed, whether or not my finances are exhausted.	0	1	2	3	4
Not being a financial burden to those around me.	0	1	2	3	4
Not having my health care costs affect the financial situations of those I care about.	0	1	2	3	4

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious or spiritual beliefs should affect my heath care: _____

_____

My religion/spirituality is:_____

My congregation/spiritual community (name, city, state):_____

_____

I wish to have my priest/pastor/rabbi/shaman/spiritual leader consulted. **Yes** **No**
If yes, the person to be contacted is: _____

My Medical Treatment Preferences

Do you have strong feelings or wishes about certain medical treatments, especially those that might prolong your life? It's a good idea to discuss these medical treatments with your health care provider to understand how they might impact the quality of your life, then indicate your wishes below.

Medical Procedure: Ventilator/ Respirator (a breathing machine) **Application:** When you are unable to breathe on your own. A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure. **Sustained Condition:** You cannot talk or eat by mouth on this machine.	My feelings about this procedure: _____ _____ _____ _____ _____
Medical Procedure: Nutrition support and hydration **Application:** When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely. **Sustained Condition:** Feeding solutions can be put through a tube in your stomach, nose, intestine or veins.	My feelings about this procedure: _____ _____ _____ _____ _____
Medical Procedure: Cardiopulmonary resuscitation (CPR) **Application:** Actions to make your heart and lungs start if they stop, including pounding on your chest, electric shocks, medications and a tube in your throat. A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.	My feelings about this procedure: _____ _____ _____ _____ _____
Medical Procedure: Dialysis **Application:** A mechanical means of cleaning the blood when kidneys are not working.	My feelings about this procedure: _____ _____ _____ _____

My Medical Treatment Preferences (continued)

My Medical Treatment Preferences

My feelings or concerns about other medical treatment include:

If I am pregnant, my feelings about medical treatment would include:

Feelings About Quality and Length of Life

I have the following feelings about whether life should be preserved as long as possible:

The following types of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive:

My Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

- ☐ At home
- ☐ At a hospital. Which one?
- ☐ At a nursing home. Which one?
- ☐ Through hospice services/care. Which one?
- ☐ From other health care providers. Which ones?

Other wishes I have about my care if I am dying:

Additional Health Care

My decision makers should also know these things about me to help them make decisions about my health care:

My Wishes About Donating Organs, Tissues or Other Body Parts

Initial the lines that apply to you:

_____ I DO wish to donate organs, tissue or other body parts when I die.

_____ Any needed organs, tissue or other body parts

_____ Only the following listed organs, tissue or body parts: _____

Limitations or special wishes I have include:_____

_____ I DO NOT wish to donate organs, tissue or other body parts when I die.

Signature

I agree that these are my health care instructions and I have completed this willingly. This worksheet is an attachment to my Health Care Directive.

Name (Print): _____

Signature: _____ Date completed:_____

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of _____, County of _____

On _____ before me, _____

personally appeared _____

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument, the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____ (Notary Seal)

(Signature)

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