

## Advance Care Planning - My Personal Values

*This tool will be beneficial for you in determining an appropriate health care agent. Mark the extent to which you agree or disagree with each statement. If you are unsure, check "not sure." Share your answers with the person whom you think would be a good decision-maker for you. Any discrepancy between your preferences and those indicated by your proposed agent are great beginning points for conversation.*

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
<b>Level of Independent Decision-Making</b>					
1. I want to remain involved in health care decisions about my care.	<input type="checkbox"/>				
2. I want information provided to me about my health care (e.g. understanding my disease, likely outcome of treatment, benefits, risks, reasonable alternative treatments, and consequences if I select no treatment).	<input type="checkbox"/>				
3. I want to know if the treatment being considered is likely to achieve the goals I've set for my life/health without causing excessive burden on me or my family.	<input type="checkbox"/>				
4. I have the right to refuse medical treatment even if the refusal may shorten my life.	<input type="checkbox"/>				
5. It is important to me to know about my diagnosis and overall health, even if there is little chance for recovery or no possibility of recovery.	<input type="checkbox"/>				
<b>Social/Relational Activities</b>					
6. I want to be able to engage in activities that bring me meaning and purpose (e.g. visiting others, attending church or synagogue, or travel).	<input type="checkbox"/>				
7. It is important to me to be able to recognize my immediate family members throughout my treatment/dying process.	<input type="checkbox"/>				
8. I want to be able to talk to and understand others.	<input type="checkbox"/>				
9. I believe cost/insurance coverage should be considered in the type of treatment I receive.	<input type="checkbox"/>				



Strongly Agree    Agree    Not Sure    Disagree    Strongly Disagree

**Aggressiveness of Medical Treatment at End of Life**

10. I want feeding tubes, including stomach tubes or nasogastric tubes (which are placed down the nose), or intravenous feedings, unless it reduces my comfort or increases my pain.	<input type="checkbox"/>				
11. I would like all treatments possible to keep me alive even if I can no longer experience things I've found meaningful.	<input type="checkbox"/>				
12. I want all attempts to start my heart or breathing if it stops or receive other types of advanced life support (e.g. dialysis if my kidney's fail; breathing machine if I cannot breathe on my own; medications to address my blood pressure issues, etc).	<input type="checkbox"/>				
13. I want consideration given to the use of any medical treatments possible if these treatments would help me to return to a life where I can experience joy, love and the things I find important.	<input type="checkbox"/>				
14. I would like to have an autopsy done so that more can be learned about my illness.	<input type="checkbox"/>				

**General Guidelines**

15. I do not want to be indefinitely dependent on medical interventions (e.g., breathing machines) only to be kept alive.	<input type="checkbox"/>				
16. I want to be able to die at home, if possible, rather than in a hospital or nursing home.	<input type="checkbox"/>				
17. I want to be an organ, eye and tissue donor.	<input type="checkbox"/>				

