Healthcare Directive Plan

This document helps you share your medical wishes clearly with your loved ones and healthcare team. Fill it out at your own pace. You can update it anytime.

About You

Full Name: _____

Date of Birth: _____

Phone: _____

Address: _____

Who Can Make Decisions for You?

Choose someone you trust to speak for you if you cannot.

Primary Decision-Maker Name: _____

Relationship: _____

Phone: _____

Backup Decision-Maker Name: _____

Relationship: _____

Phone: _____

Your Care Preferences

If you are very sick and cannot speak for yourself, what kind of care would you want?

- ☐ I want all possible treatments to keep me alive.
- ☐ I want treatments only if there is a good chance of recovery.
- ☐ I want comfort care only (focus on pain relief and quality of life).

Anything else you want your care team to know:

Life Support Choices

These choices guide doctors in emergencies.

- [ ] Try CPR (restart my heart).
- [ ] Do NOT try CPR.
- [ ] Use a breathing machine if needed.
- [ ] Try it for a short time only.
- [ ] Do NOT use a breathing machine.
- [ ] Provide feeding tubes if needed.
- [ ] Try feeding support for a short time.
- [ ] Do NOT use feeding tubes.

Comfort & Pain Care

- [ ] Focus on keeping me comfortable, even if it shortens my life.
- [ ] Balance pain relief with staying alert.

Other wishes:

Where I Prefer to Receive Care

- [ ] At home
- [ ] In hospice care
- [ ] In a hospital

Organ Donation

- [ ] I want to donate my organs/tissues.
- [ ] I do NOT want to donate.

Signatures

Signing this document helps ensure your wishes are honored. Your Signature:

_____

Date: _____

Witness 1 Signature: Witness 2 Signature: