

## PERSONAL WISHES STATEMENT

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

**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 (initial 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. Some examples of types of such treatment include:

\_\_\_\_\_ If I cannot drink, I do not want to receive fluids through a needle placed in my vein unless necessary to keep me comfortable.

\_\_\_\_\_ If I cannot eat, I do not want a tube inserted in my nose, mouth or surgically placed to give me food.

\_\_\_\_\_ 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, if needed.

\_\_\_\_\_ 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.

\_\_\_\_\_ I do not wish spiritual support.

\_\_\_\_\_ If possible, I wish to be an organ donor.

\_\_\_\_\_ Following is additional guidance for my Health Care Agent's consideration:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_