Disaster – Emergency Planning

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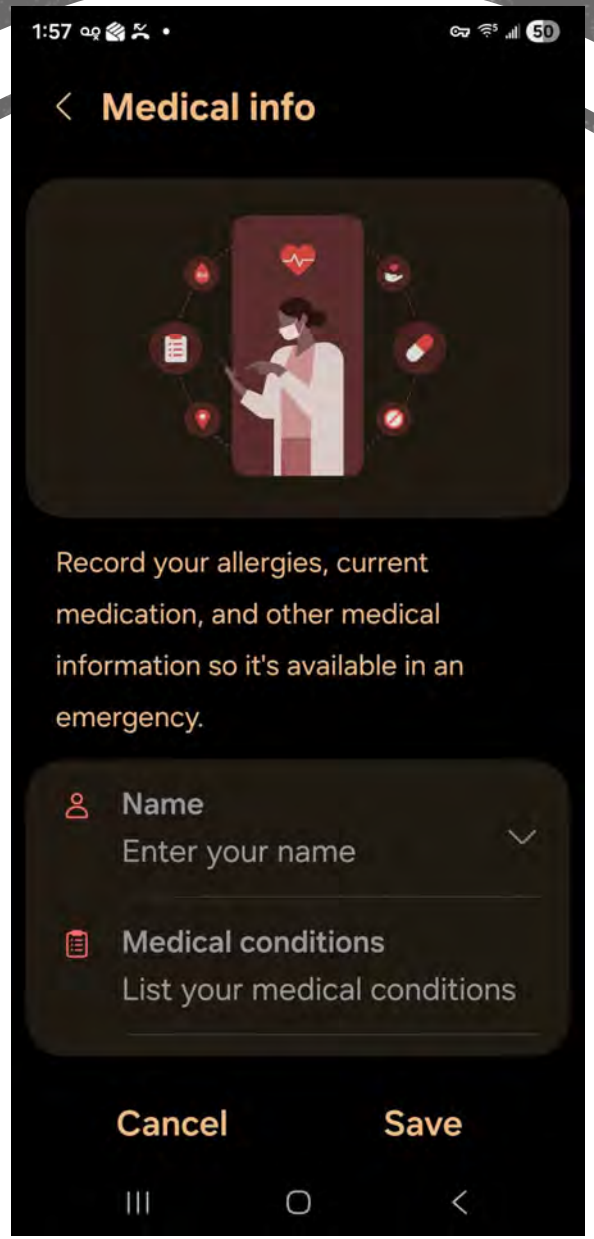
HOW TO ADD EMERGENCY MEDICAL INFORMATION TO YOUR PHONE

Step-by-step instructions using your phone's built-in Medical Info feature.



20 YEARS IN BUSINESS
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STEP 1: OPEN MEDICAL INFO

- Open the Contacts or Emergency Settings on your phone.
- Tap on Medical info to begin entering your emergency health details.

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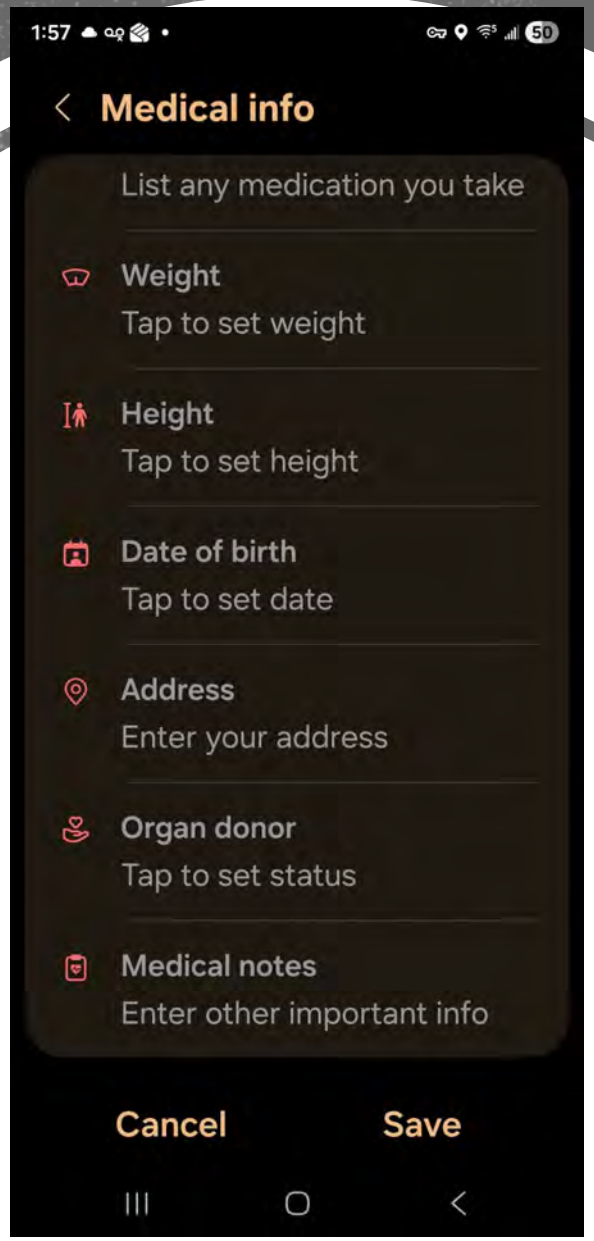
STEP 2: ENTER CORE MEDICAL DETAILS

- Enter your name and medical conditions.
- Add your blood type and any allergies.



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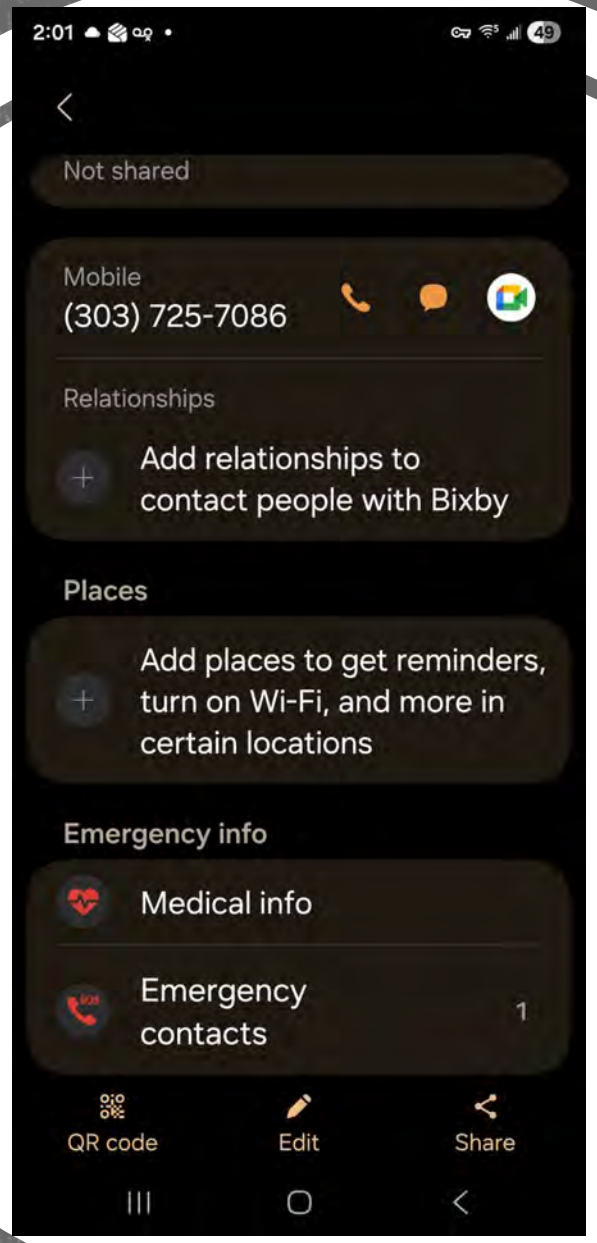
STEP 3: ADD MEDICATIONS AND PERSONAL DETAILS

- List current medications.
- Add your height, weight, date of birth, and address.



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STEP 4: FINALIZE EMERGENCY ACCESS

- Confirm emergency contacts are listed.
- Ensure Medical Info is enabled for emergency access from the lock screen.

FINAL CHECKLIST

- ✓ Name and date of birth entered
- ✓ Medical conditions listed
- ✓ Allergies clearly stated
- ✓ Current medications included
- ✓ Emergency contacts confirmed
- ✓ Medical Info accessible from lock screen

EMERGENCY TREATMENT ORDERS

NEBRASKA: NETO FORM

COLORADO: MOST FORM

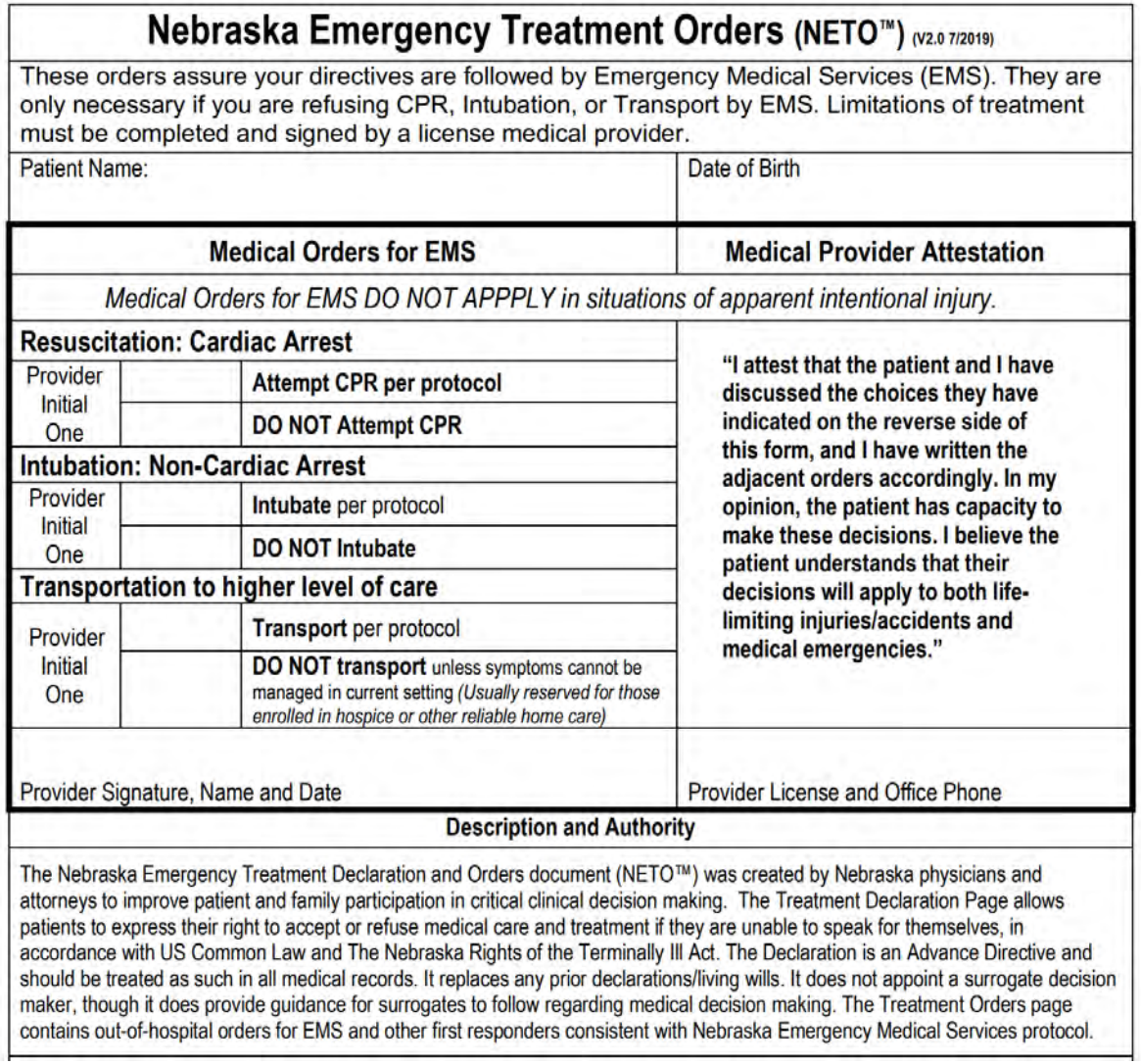
The form stuck to the side of your fridge for emergency personnel.

Nebraska Emergency Treatment Orders(NETO)

NETO form master may be downloaded from

https://nebraskahealthnetwork.com/wp-content/uploads/2019/10/NETO-ADULT-V2-FINAL-2019.pdf

This is the form emergency personnel should request in your home.



Nebraska Emergency Treatment Orders (NETO™) (V2.0 7/2019)

These orders assure your directives are followed by Emergency Medical Services (EMS). They are only necessary if you are refusing CPR, Intubation, or Transport by EMS. Limitations of treatment must be completed and signed by a license medical provider.

Patient Name: | Date of Birth

Medical Orders for EMS			Medical Provider Attestation
Medical Orders for EMS DO NOT APPPLY in situations of apparent intentional injury.			
Resuscitation: Cardiac Arrest			**"I attest that the patient and I have discussed the choices they have indicated on the reverse side of this form, and I have written the adjacent orders accordingly. In my opinion, the patient has capacity to make these decisions. I believe the patient understands that their decisions will apply to both life-limiting injuries/accidents and medical emergencies."**
Provider Initial One		**Attempt CPR per protocol**	
		DO NOT Attempt CPR	
Intubation: Non-Cardiac Arrest			
Provider Initial One		**Intubate** per protocol	
		DO NOT Intubate	
Transportation to higher level of care			
Provider Initial One		**Transport** per protocol	
		DO NOT transport unless symptoms cannot be managed in current setting *(Usually reserved for those enrolled in hospice or other reliable home care)*	
Provider Signature, Name and Date			Provider License and Office Phone

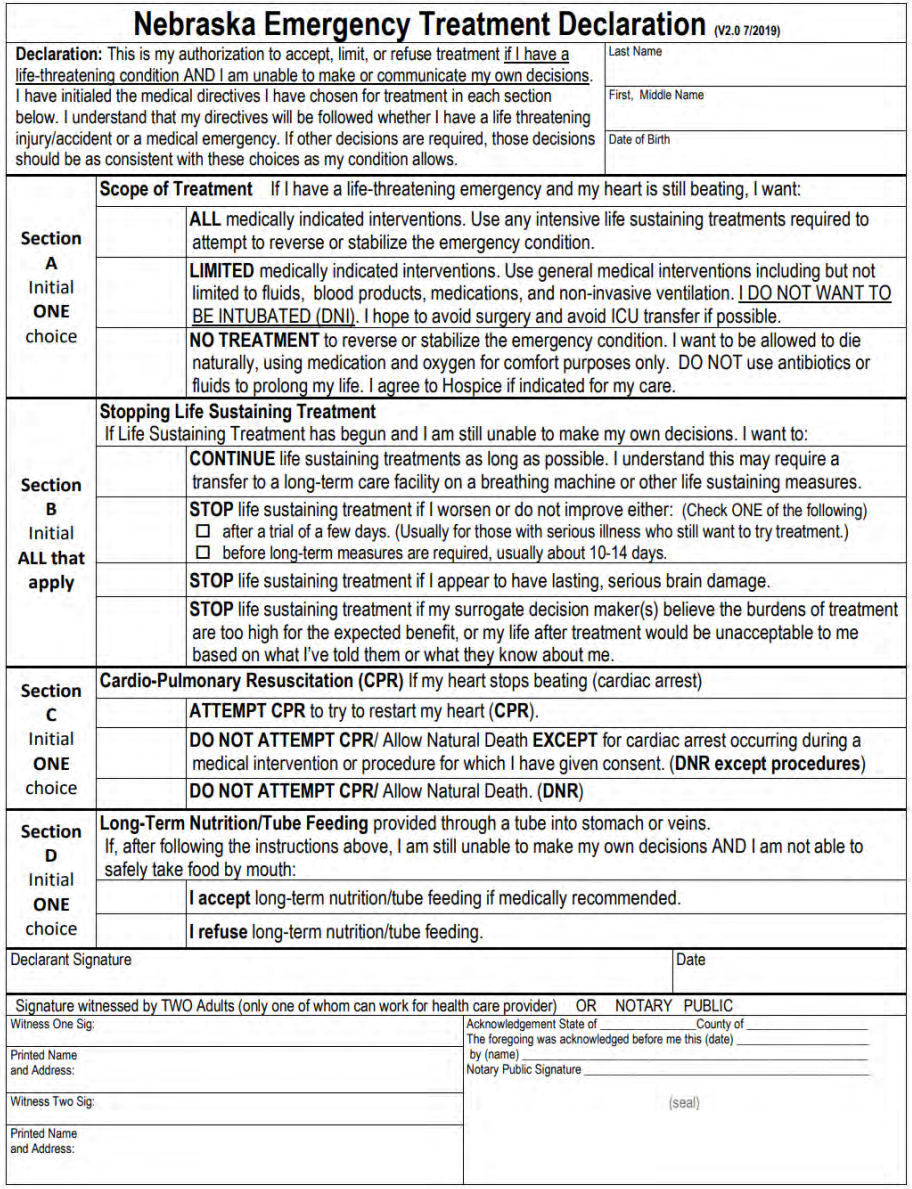
Description and Authority

The Nebraska Emergency Treatment Declaration and Orders document (NETO™) was created by Nebraska physicians and attorneys to improve patient and family participation in critical clinical decision making. The Treatment Declaration Page allows patients to express their right to accept or refuse medical care and treatment if they are unable to speak for themselves, in accordance with US Common Law and The Nebraska Rights of the Terminally Ill Act. The Declaration is an Advance Directive and should be treated as such in all medical records. It replaces any prior declarations/living wills. It does not appoint a surrogate decision maker, though it does provide guidance for surrogates to follow regarding medical decision making. The Treatment Orders page contains out-of-hospital orders for EMS and other first responders consistent with Nebraska Emergency Medical Services protocol.

Nebraska Emergency Treatment Orders(NETO)

Important

- See at the bottom, "Signature witnessed by TWO Adults (only one of whom can work for health care provider) OR a NOTARY PUBLIC."



Nebraska Emergency Treatment Declaration (V2.0 7/2019)

Declaration: This is my authorization to accept, limit, or refuse treatment if I have a life-threatening condition AND I am unable to make or communicate my own decisions. I have initialed the medical directives I have chosen for treatment in each section below. I understand that my directives will be followed whether I have a life threatening injury/accident or a medical emergency. If other decisions are required, those decisions should be as consistent with these choices as my condition allows.

Last Name

First, Middle Name

Date of Birth

Section A Initial **ONE** choice

Scope of Treatment If I have a life-threatening emergency and my heart is still beating, I want:

- ☐ **ALL** medically indicated interventions. Use any intensive life sustaining treatments required to attempt to reverse or stabilize the emergency condition.
- ☐ **LIMITED** medically indicated interventions. Use general medical interventions including but not limited to fluids, blood products, medications, and non-invasive ventilation. I DO NOT WANT TO BE INTUBATED (DNI). I hope to avoid surgery and avoid ICU transfer if possible.
- ☐ **NO TREATMENT** to reverse or stabilize the emergency condition. I want to be allowed to die naturally, using medication and oxygen for comfort purposes only. DO NOT use antibiotics or fluids to prolong my life. I agree to Hospice if indicated for my care.

Section B Initial **ALL that apply**

Stopping Life Sustaining Treatment
If Life Sustaining Treatment has begun and I am still unable to make my own decisions. I want to:

- ☐ **CONTINUE** life sustaining treatments as long as possible. I understand this may require a transfer to a long-term care facility on a breathing machine or other life sustaining measures.
- ☐ **STOP** life sustaining treatment if I worsen or do not improve either: (Check ONE of the following)
  - ☐ after a trial of a few days. (Usually for those with serious illness who still want to try treatment.)
  - ☐ before long-term measures are required, usually about 10-14 days.
- ☐ **STOP** life sustaining treatment if I appear to have lasting, serious brain damage.
- ☐ **STOP** life sustaining treatment if my surrogate decision maker(s) believe the burdens of treatment are too high for the expected benefit, or my life after treatment would be unacceptable to me based on what I've told them or what they know about me.

Section C Initial **ONE** choice

Cardio-Pulmonary Resuscitation (CPR) If my heart stops beating (cardiac arrest)

- ☐ **ATTEMPT CPR** to try to restart my heart (**CPR**).
- ☐ **DO NOT ATTEMPT CPR**/ Allow Natural Death **EXCEPT** for cardiac arrest occurring during a medical intervention or procedure for which I have given consent. (**DNR except procedures**)
- ☐ **DO NOT ATTEMPT CPR**/ Allow Natural Death. (**DNR**)

Section D Initial **ONE** choice

Long-Term Nutrition/Tube Feeding provided through a tube into stomach or veins.
If, after following the instructions above, I am still unable to make my own decisions AND I am not able to safely take food by mouth:

- ☐ **I accept** long-term nutrition/tube feeding if medically recommended.
- ☐ **I refuse** long-term nutrition/tube feeding.

Declarant Signature | Date

Signature witnessed by TWO Adults (only one of whom can work for health care provider) OR NOTARY PUBLIC

Witness One Sig:

Printed Name and Address:

Witness Two Sig:

Printed Name and Address:

Acknowledgement State of _____ County of _____
The foregoing was acknowledged before me this (date) _____
by (name) _____
Notary Public Signature _____

(seal)

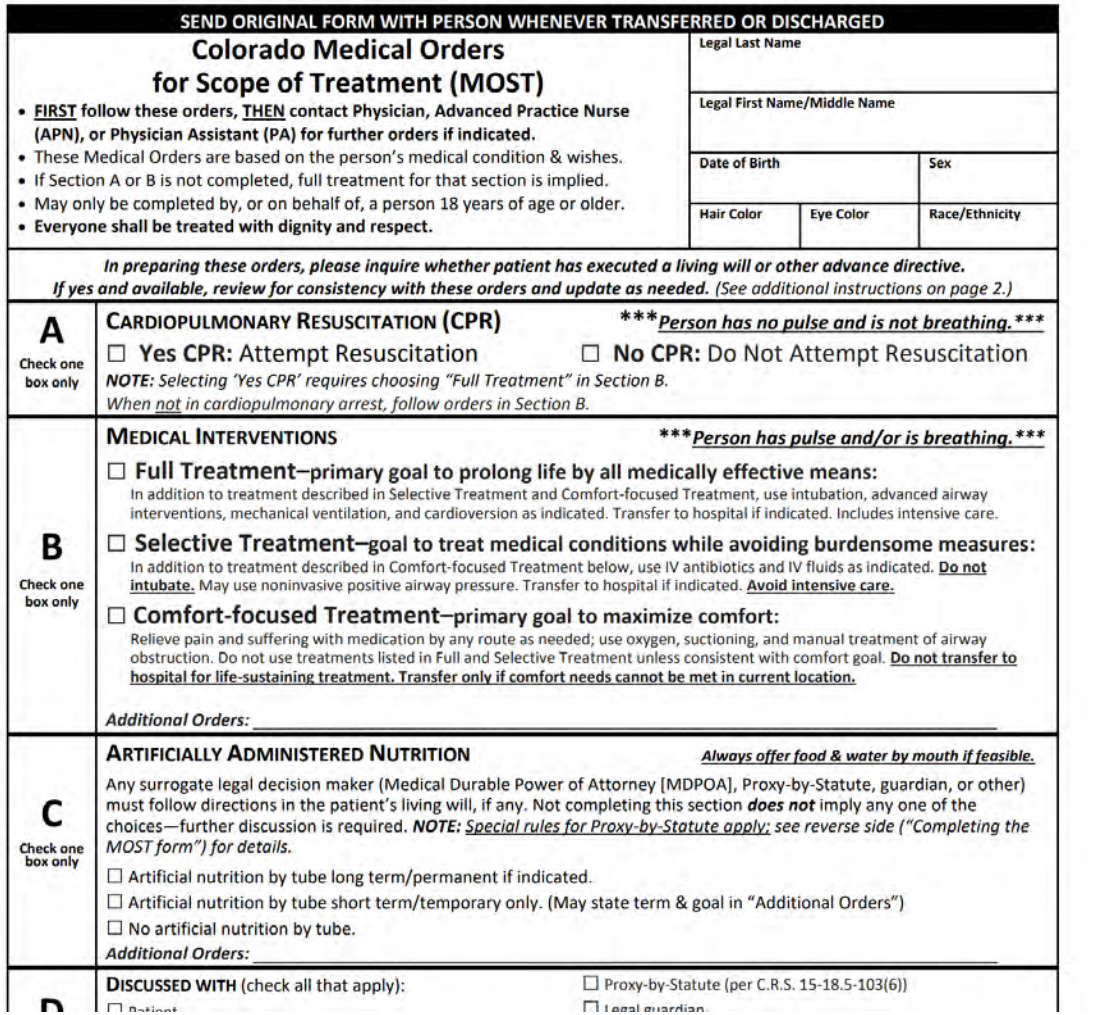
Colorado Medical Orders for Scope of Treatment (MOST)

MOST form master may be downloaded from https://www.civhc.org/programs-and-services/most-program/

and photocopied onto Astrobrights® "Vulcan Green" or "Terra Green" 60lb paper.

This special paper is strongly encouraged but not required.

This is the form emergency personnel should request in your home.



SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Legal Last Name | Legal First Name/Middle Name | Date of Birth | Sex | Hair Color | Eye Color | Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. *(See additional instructions on page 2.)*

A Check one box only — **CARDIOPULMONARY RESUSCITATION (CPR)** ***Person has no pulse and is not breathing.***

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
When not in cardiopulmonary arrest, follow orders in Section B.

B Check one box only — **MEDICAL INTERVENTIONS** ***Person has pulse and/or is breathing.***

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

☐ **Selective Treatment–goal to treat medical conditions while avoiding burdensome measures:**
In addition to treatment described in Comfort-focused Treatment below, use IV antibiotics and IV fluids as indicated. Do not intubate. May use noninvasive positive airway pressure. Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort-focused Treatment–primary goal to maximize comfort:**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.

Additional Orders: _____

C Check one box only — **ARTIFICIALLY ADMINISTERED NUTRITION** *Always offer food & water by mouth if feasible.*

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

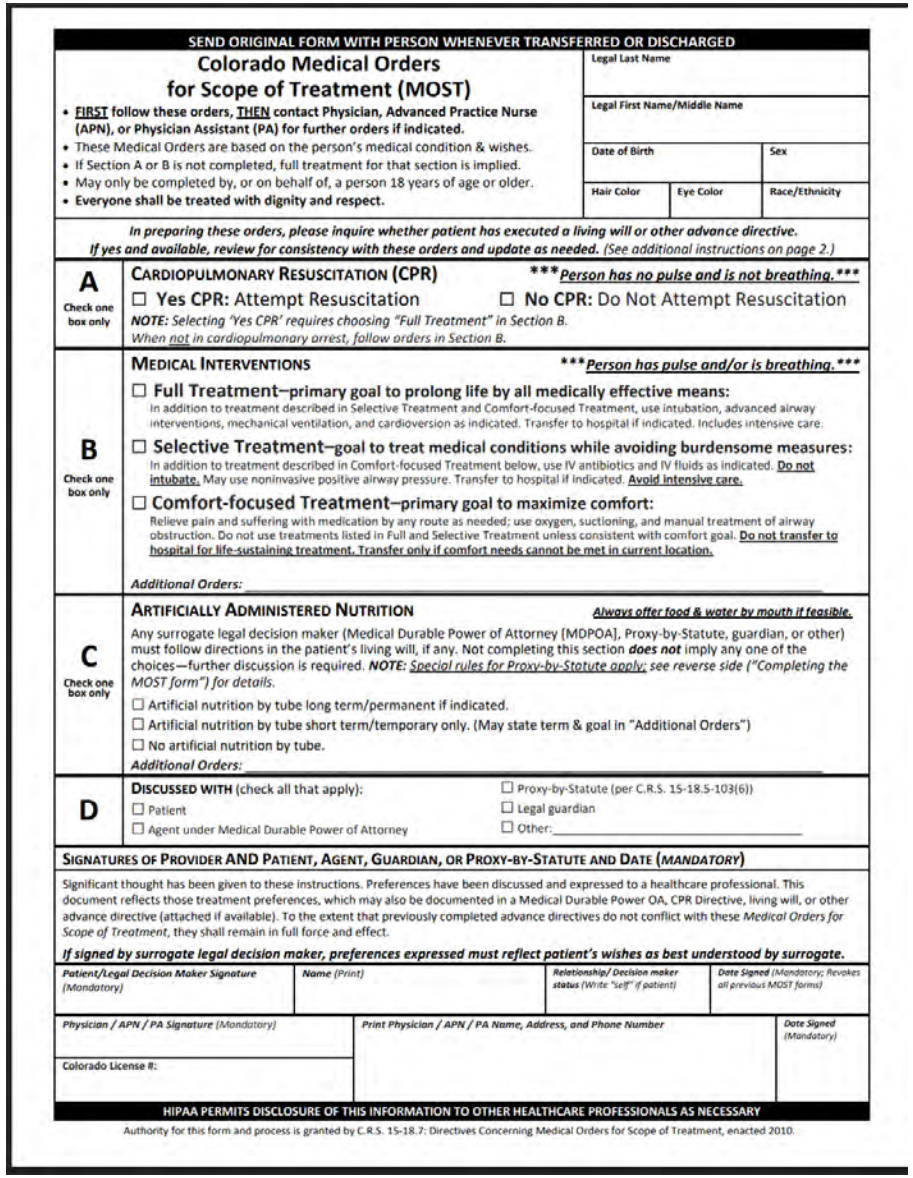
☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.
Additional Orders: _____

D — **DISCUSSED WITH** (check all that apply): ☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6))

Colorado Medical Orders for Scope of Treatment (MOST)

Two important notes:

1. See at the top, "Send original form with person whenever transferred or discharged."
2. See at the bottom, the mandatory signature by a physician, APN, or PA.



SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (MOST)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA) for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- If Section A or B is not completed, full treatment for that section is implied.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Legal Last Name | Legal First Name/Middle Name | Date of Birth | Sex | Hair Color | Eye Color | Race/Ethnicity

In preparing these orders, please inquire whether patient has executed a living will or other advance directive. If yes and available, review for consistency with these orders and update as needed. *(See additional instructions on page 2.)*

A Check one box only — **CARDIOPULMONARY RESUSCITATION (CPR)** ******Person has no pulse and is not breathing.******

☐ **Yes CPR:** Attempt Resuscitation ☐ **No CPR:** Do Not Attempt Resuscitation

NOTE: *Selecting 'Yes CPR' requires choosing "Full Treatment" in Section B.*
When not in cardiopulmonary arrest, follow orders in Section B.

B Check one box only — **MEDICAL INTERVENTIONS** ******Person has pulse and/or is breathing.******

☐ **Full Treatment–primary goal to prolong life by all medically effective means:**
In addition to treatment described in Selective Treatment and Comfort-focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.

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Additional Orders: _____

C Check one box only — **ARTIFICIALLY ADMINISTERED NUTRITION** ***Always offer food & water by mouth if feasible.***

Any surrogate legal decision maker (Medical Durable Power of Attorney [MDPOA], Proxy-by-Statute, guardian, or other) must follow directions in the patient's living will, if any. Not completing this section ***does not*** imply any one of the choices—further discussion is required. ***NOTE:*** *Special rules for Proxy-by-Statute apply; see reverse side ("Completing the MOST form") for details.*

☐ Artificial nutrition by tube long term/permanent if indicated.
☐ Artificial nutrition by tube short term/temporary only. (May state term & goal in "Additional Orders")
☐ No artificial nutrition by tube.

Additional Orders: _____

D — **DISCUSSED WITH** (check all that apply):

☐ Patient ☐ Agent under Medical Durable Power of Attorney ☐ Proxy-by-Statute (per C.R.S. 15-18.5-103(6)) ☐ Legal guardian ☐ Other: _____

SIGNATURES OF PROVIDER AND PATIENT, AGENT, GUARDIAN, OR PROXY-BY-STATUTE AND DATE (*MANDATORY*)

Significant thought has been given to these instructions. Preferences have been discussed and expressed to a healthcare professional. This document reflects those treatment preferences, which may also be documented in a Medical Durable Power OA, CPR Directive, living will, or other advance directive (attached if available). To the extent that previously completed advance directives do not conflict with these *Medical Orders for Scope of Treatment*, they shall remain in full force and effect.

If signed by surrogate legal decision maker, preferences expressed must reflect patient's wishes as best understood by surrogate.

Patient/Legal Decision Maker Signature (Mandatory) | *Name (Print)* | *Relationship/ Decision maker status (Write "self" if patient)* | *Date Signed (Mandatory; Revokes all previous MOST forms)*

Physician / APN / PA Signature (Mandatory) | *Print Physician / APN / PA Name, Address, and Phone Number* | *Date Signed (Mandatory)*

Colorado License #:

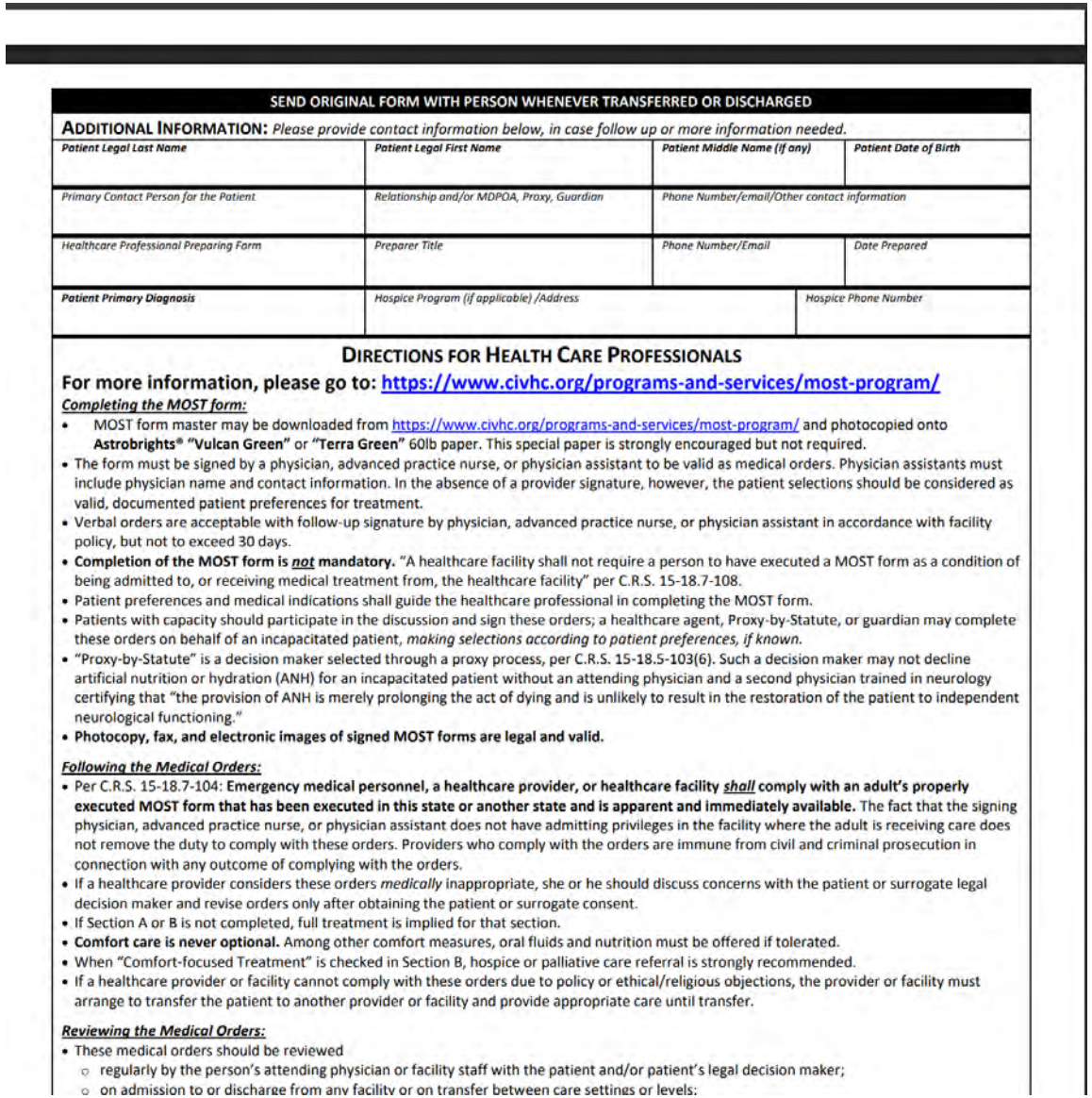
HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

Authority for this form and process is granted by C.R.S. 15-18.7: Directives Concerning Medical Orders for Scope of Treatment, enacted 2010.

Colorado Medical Orders for Scope of Treatment (MOST)

Please read it carefully and update it as you see fit.

It is recommended you update it every two years or when your health status changes.



SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

ADDITIONAL INFORMATION: *Please provide contact information below, in case follow up or more information needed.*

Patient Legal Last Name	*Patient Legal First Name*	*Patient Middle Name (if any)*	*Patient Date of Birth*

Primary Contact Person for the Patient	*Relationship and/or MDPOA, Proxy, Guardian*	*Phone Number/email/Other contact information*

Healthcare Professional Preparing Form	*Preparer Title*	*Phone Number/Email*	*Date Prepared*

Patient Primary Diagnosis	*Hospice Program (if applicable) /Address*	*Hospice Phone Number*

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

For more information, please go to: https://www.civhc.org/programs-and-services/most-program/

Completing the MOST form:

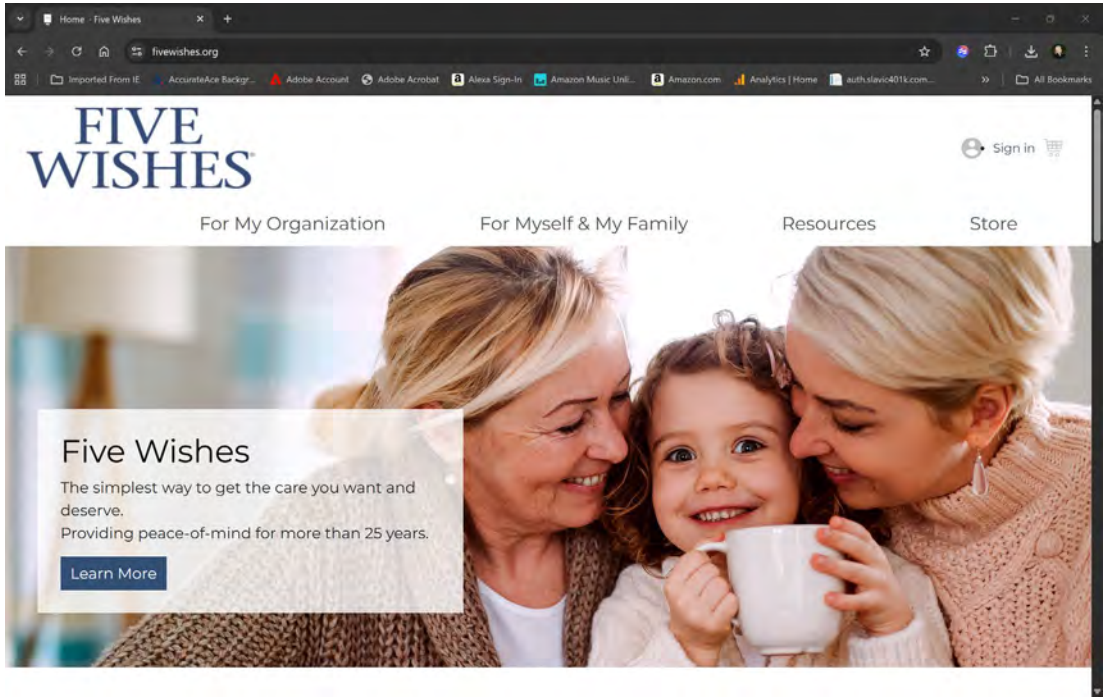
- MOST form master may be downloaded from https://www.civhc.org/programs-and-services/most-program/ and photocopied onto **Astrobrights® "Vulcan Green"** or **"Terra Green"** 60lb paper. This special paper is strongly encouraged but not required.
- The form must be signed by a physician, advanced practice nurse, or physician assistant to be valid as medical orders. Physician assistants must include physician name and contact information. In the absence of a provider signature, however, the patient selections should be considered as valid, documented patient preferences for treatment.
- Verbal orders are acceptable with follow-up signature by physician, advanced practice nurse, or physician assistant in accordance with facility policy, but not to exceed 30 days.
- **Completion of the MOST form is *not* mandatory.** "A healthcare facility shall not require a person to have executed a MOST form as a condition of being admitted to, or receiving medical treatment from, the healthcare facility" per C.R.S. 15-18.7-108.
- Patient preferences and medical indications shall guide the healthcare professional in completing the MOST form.
- Patients with capacity should participate in the discussion and sign these orders; a healthcare agent, Proxy-by-Statute, or guardian may complete these orders on behalf of an incapacitated patient, *making selections according to patient preferences, if known.*
- "Proxy-by-Statute" is a decision maker selected through a proxy process, per C.R.S. 15-18.5-103(6). Such a decision maker may not decline artificial nutrition or hydration (ANH) for an incapacitated patient without an attending physician and a second physician trained in neurology certifying that "the provision of ANH is merely prolonging the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning."
- **Photocopy, fax, and electronic images of signed MOST forms are legal and valid.**

Following the Medical Orders:

- Per C.R.S. 15-18.7-104: **Emergency medical personnel, a healthcare provider, or healthcare facility *shall* comply with an adult's properly executed MOST form that has been executed in this state or another state and is apparent and immediately available.** The fact that the signing physician, advanced practice nurse, or physician assistant does not have admitting privileges in the facility where the adult is receiving care does not remove the duty to comply with these orders. Providers who comply with the orders are immune from civil and criminal prosecution in connection with any outcome of complying with the orders.
- If a healthcare provider considers these orders *medically* inappropriate, she or he should discuss concerns with the patient or surrogate legal decision maker and revise orders only after obtaining the patient or surrogate consent.
- If Section A or B is not completed, full treatment is implied for that section.
- **Comfort care is never optional.** Among other comfort measures, oral fluids and nutrition must be offered if tolerated.
- When "Comfort-focused Treatment" is checked in Section B, hospice or palliative care referral is strongly recommended.
- If a healthcare provider or facility cannot comply with these orders due to policy or ethical/religious objections, the provider or facility must arrange to transfer the patient to another provider or facility and provide appropriate care until transfer.

Reviewing the Medical Orders:

- These medical orders should be reviewed
  - regularly by the person's attending physician or facility staff with the patient and/or patient's legal decision maker;
  - on admission to or discharge from any facility or on transfer between care settings or levels;



FIVE WISHES

Healthcare Power of Attorney aka Living Will aka Advance Directive

FIVE WISHES

Five Wishes Digital

Complete and sign your document online. Customized to meet requirements all 50 states. Make unlimited revisions without any time limits.

$7.50
volume discounts available – starting at 50 or more

Get Started Now

Five Wishes Paper

Five Wishes Paper is a traditional printed booklet to complete by hand. It meets requirements in nearly all states. If you live in one of only four states (New Hampshire, Kansas, Ohio, or Texas) you can still use the Five Wishes Paper but may need to take an extra step.

Available in 30 languages

$5
volume discounts available – starting at 10 or more

View Sample | Order Now

FIVE WISHES®

MY WISH FOR:

1 The Person I Want to Make Care Decisions for Me When I Can't

2 The Kind of Medical Treatment I Want or Don't Want

3 How Comfortable I Want to Be

4 How I Want People to Treat Me

5 What I Want My Loved Ones to Know

Print Your Name

Birthdate

WISH 1

The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- *My attending or treating doctor finds I am no longer able to make health care choices, **AND***
- *Another health care professional agrees that this is true.*

If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

The Person I Choose As My Health Care Agent Is:

First Choice Name | Phone

Address | City/State/Zip

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

Second Choice Name | Third Choice Name

Address | Address

City/State/Zip | City/State/Zip

Phone | Phone

Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member **may not** be the best choice because they are too emotionally involved. Sometimes they **are** the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be **at least 18 years or older** (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

WISH 2

My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want to be comfortable. Wish 3 says what can be done to make me comfortable.
- I want to be offered food and fluids by mouth if it is safe for me to eat and drink. I want to be kept clean and warm.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.

What "Life-Support Treatment" Means To Me

Life-support treatment means any medical procedure, device, or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a **Do Not Resuscitate** form or bracelet. Many states require a person to have a **Do Not Resuscitate** form filled out and signed by a doctor if you choose not to be resuscitated. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a **Do Not Resuscitate** form filled out.

Here is the kind of medical treatment that I want or don't want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends, and all others to know these directions.

Close To Death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In A Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write "end-stage condition." That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)

The next three wishes deal with my personal, spiritual, and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

WISH 3

My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious or spiritual readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional, and spiritual care for me and my loved ones.

WISH 4

My Wish For How I Want People To Treat Me.

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be visited by a chaplain or clergy.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- I wish to have my favorite music played when possible until my time of death.
- I want to die in my home, if that can be done.
- I wish to be called by my name. Please call me: _____

WISH 5

My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends, and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried *OR* cremated.
- My body or remains should be put in the following location: _____
- The following person knows my funeral wishes: _____

If anyone asks how I want to be remembered, please say the following about me:

_____

_____

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings, or other specific requests that you have):

_____

_____

It is important for my health care providers to know what matters most to me. I wish for them to know the following:

_____

_____

Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Or you may want to give instructions on what should be done with your social media or other electronic records. Please attach a separate sheet of paper if you need more space.

_____

_____

Review

Emergency Medical Info on Your Phone

The MOST Form

Five Wishes

Final Tip

Double check your beneficiaries!

Questions?

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Thank You!