

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

For more information or for assistance with this document, please contact:



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Five Wishes has captured the hearts and minds of Americans who want to maintain their human dignity and need help expressing their wishes. It is a gift to your family members and friends so that they won't have to guess what you want. *Five Wishes* was written to meet the legal requirements under the health decision statutes of 34 states and the District of Columbia.

FIVE WISHES

If you live in the District of Columbia or one of the 34 states listed below, you can use *Five Wishes* and have the peace of mind to know that it meets your state's requirements under the law:

Alaska	Hawaii	Mississippi	Pennsylvania
Arizona	Idaho	Missouri	Rhode Island
Arkansas	Illinois	Montana	South Carolina
California	Iowa	Nebraska	South Dakota
Colorado	Louisiana	New Jersey	Tennessee
Connecticut	Maine	New Mexico	Virginia
Delaware	Maryland	New York	Washington
District of Columbia	Massachusetts	North Carolina	West Virginia
Florida	Michigan	North Dakota	Wyoming
Georgia	Minnesota	Oklahoma	

This will be a helpful guide to your care providers. Most doctors and health care professionals understand that they have a duty to listen to your wishes no matter how you express them.

Talk to your doctor during your next office visit. Give your doctor a copy of *Five Wishes* and ask to have a talk about it. Make sure your doctor understands your wishes and will honor them. Ask him or her to urge other doctors treating you to honor them.

You have a right to decide what kind of medical treatment you want or don't want when you are seriously ill and your death is expected.

You also have a right to choose a person to make health care decisions for you when you are no longer able to speak or think clearly. *Five Wishes* helps you exercise these rights. But remember, your doctor needs to know, and be willing to follow, your wishes.

How Do I Change To *Five Wishes*

If you already have completed a living will or durable power of attorney for health care (such as a previous edition of *Five Wishes*), you may want to change over to the new *Five Wishes* instead. All you need to do to is fill out and sign your new edition of *Five Wishes* as directed in the instructions. This takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will and/or durable power of attorney for health care, or write "revoked" in large letters across the copy you have (notify your lawyer if he or she helped prepare those old forms for you), AND
- Tell your Health Care Agent, family members and doctor that you have filled out the new *Five Wishes*, and tell them what your wishes are.

Print your name

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:

1. My attending or treating doctor finds that I am no longer able to make health care choices,

AND

2. 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.

PICKING THE RIGHT PERSON TO BE Your HEALTH CARE AGENT

Choose someone who knows you very well and cares about you, and who can make difficult decisions. Sometimes a spouse or family member is not the best choice because they are too emotionally involved with you. Sometimes they are the best choice. You know best. Make sure you 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 that they are ready to help you when you need them.

Whether you choose your spouse, family member or friend to be your Health Care Agent, make sure you talk about your

wishes with this person and that he or she agrees to respect and follow them.

Print your birthdate

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 owner or operator of a health or residential or community care facility serving you.
- 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.

The person I choose as my Health Care Agent is:

Name

Phone

Address

City/State/Zip

If this person

- Is not able or willing to make these choices for me,
- Is divorced or legally separated from me, OR
- This person has died,

Then these people are my next choices:

Second Choice Name

Phone

Address

City/State/Zip

Third Choice Name

D. If I am in a coma and I am 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 postpone 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 be helpful, but I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

E. If I have permanent and severe brain damage and I am 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 recover, and life-support treatment would only postpone 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.

When you talk with your family, doctor, Health Care Agent, and priest, minister or rabbi about what you have chosen, you may feel that the above instructions do not express all of your wishes, or your own religious beliefs. Please use the space below to make very clear what you want, and under what conditions.

F. If I am 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 and you are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you get better.)

(Please leave the space blank if you have none).

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. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are in the process of dying. Please check with your doctor or with your local hospital, hospice, or health officials to see if you need to have a **Do Not Resuscitate** form filled out.

PART B

I want to be treated with dignity near the end of my life as Part A of Five Wishes is followed. To be treated with dignity means that I would like people to do the things written in Part B 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 the things, or are not required by law to do the things written in Part B.

I do not expect my wishes in Part B to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes in Part B to excuse my doctor or other health care providers from giving me the proper care asked for by law.

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 that 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 caregivers 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.
- I wish to have my favorite music played when possible until my time of death.
- 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 readings and well loved poems read aloud when I am near death.

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 church or synagogue told that I am sick and asked to pray for me and visit me.
- 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.
- 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 want to die in my home, if that can be done.

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

(Cross out anything that you don't agree with)

- I wish to have my family members and loved ones 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 members and friends know that I forgive them for what they may have done to me in my life.
- I wish for my family members and loved ones to know that because of the faith I have, I do not fear death itself. 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 had a terminal illness. I want them to remember me in this way after my death.
- 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.

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

The following person knows my funeral wishes: _____

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*):

Add other wishes here (*such as your wishes about donating any or all parts of your body when you die*):

RESIDENTS OF INSTITUTIONS IN CONNECTICUT, DELAWARE, GEORGIA, NEW YORK,
AND NORTH DAKOTA MUST FOLLOW SPECIAL WITNESSING RULES

If you live in certain institutions (a nursing home or other licensed long term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in the states of Connecticut, Delaware, Georgia, New York or North Dakota, you may have to follow special "witnessing requirements" for your *Five Wishes* to be valid. For further information on what you need to do if you live in an institution in one of these five states and want to fill out *Five Wishes*, please contact a social worker or patient advocate at your institution.

If you live in Connecticut, Delaware, Georgia, New York or North Dakota, and you do not live in an institution, then you can fill out the *Five Wishes* form just the way it is.

Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses. Make sure they sign their names in your presence. You do not need to have this form notarized unless you live in Missouri, North Carolina, Tennessee or West Virginia (see below).

I, _____ ask that my family, my doctors and other health care providers, my
Print Your Name
friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any prior health care advance directives of mine.

Signature: _____

Address: _____

Phone #: _____ Date: _____

**SIGNATURES SHOULD BE NOTARIZED
IN MISSOURI, NORTH CAROLINA,
TENNESSEE AND WEST VIRGINIA**

If you live in North Carolina, Tennessee or West Virginia you should have your signature, and the signatures of your witnesses, notarized on page 8. If you live in Missouri, only your signature should be notarized.

Five Wishes is meant to be a helpful resource for you as you talk with your doctor, family and others about how you want to be treated when you are seriously ill. *Five Wishes* does not try to answer all questions about all situations you may come up against. And remember, while the information in this booklet is up-to-date as of the date it was published, laws can change quickly! So if you have a specific question or problem, you should talk to a professional for medical or legal advice.

WITNESS STATEMENT (2 witnesses needed):

I declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 19 years of age and am NOT:

- the individual appointed as (agent/proxy/surrogate/ patient advocate/representative) by this document or his/her successor,
- the person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- an employee of the person's health care provider,
- financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- related to the person by blood, marriage, or adoption, and,
- to the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

Signature of Witness (1) _____

Print Name of Witness _____

Address _____

Phone Number(s) _____

Signature of Witness (2) _____

Print Name of Witness _____

Address _____

Phone Number(s) _____

If you are a resident of Missouri, North Carolina, Tennessee, or West Virginia you should have the following completed. If you live in any other state, you do not need to have the following completed.

NOTARIZATION

STATE OF _____)
)ss.
COUNTY OF _____)

On this ____ day of _____, 20____, the said _____
And _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires:

NOTARY PUBLIC

