Health Care Declaration

My health care preferences are listed below. I request that my health care team follow these requests.

Stopping Treatments to Prolong My Life

Life-support treatments are used to try and keep you alive.

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am (write initials on line if you agree):

____ I want to **stop or withhold all treatments that are prolonging my life**. This includes but is not limited to tube feedings, IV (intravenous) fluids and medications, respirator/ventilator (breathing machine), dialysis, blood products and antibiotics.

Cardiopulmonary Resuscitation (CPR)

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions, medicines, electrical shocks, and a breathing tube. I understand that CPR can save a life. I also understand that it does not work as well for people who have chronic (long-term) health problems and/or an illness that can no longer be treated.

My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information. My health care agent may act on my behalf if I cannot make my own choices.

If I do not want CPR tried, my doctor should be told about my choice. If I show below that I do not want CPR, I understand this choice alone will not stop emergency workers from attempting CPR in an emergency. Other papers may be needed to control the actions of emergency workers.

Select ONE option. Mark with your initials.

____ **I want CPR** attempted if my heart stops or if I stop breathing.

OR

____ **I want CPR** attempted if my heart stops or if I stop breathing unless my doctor decides any one of the following:

- I have an untreatable illness or injury and am dying; OR
- I have little chance of surviving if my heart or breathing stops; OR
- I have little chance of living much longer and the process of CPR would cause me significant suffering.

OR

____ **I do not want CPR** attempted if my heart stops or if I stop breathing. Rather, I want to allow a natural death.

Initials _____
Date _____

My Wishes

I understand that I will receive care to keep me comfortable. I will be offered pain medicine. I will be offered food and fluids by mouth if I am able to swallow. I have the following additional requests:

I would like the following for comfort and support (rituals, music, visitors, etc.):

The things that make life most worth living to me are:

My beliefs about when life would no longer be worth living:

My thoughts and feelings about where I would like to die:

A message to my family and friends:

How to Make This a Legal Document

In order for this document to be valid, it must be acknowledged or witnessed in one of the following ways:

- It must be signed by you in the presence of a notary public in Iowa.

OR

- It must be signed by two witnesses. You and your two witnesses must all be present when the document is signed.

If you are physically unable to sign this document, you can ask another person to sign it for you in your presence and in the presence of your witnesses OR in the presence of a notary.

If you choose to use witnesses, they must:

- Be at least 18 years old
- Watch you sign this form
- Watch the other witness sign this form

Your witnesses cannot:

- Be your health care agent or alternate health care agent
- Be your health care provider attending to you on the date that this form is signed
- Work for your health care provider

Also, one witness cannot:

- Be related to you by blood, marriage, or adoption

Sign your name at the X and write the date below:

X _____ _____/_____/_____

Sign your name Date

_____

Print your name

_____

Address City State Zip Code

OR

I cannot sign my name because:

_____

If I cannot sign my name, I ask the following person to sign for me (print name):

_____

Signature (of person asked to sign):

_____

Initials _____

Date _____

Notary Public

State of _____) County of _____)

This form was acknowledged before me on _____ (date)

by _____
Name of Person

_____
Signature of Notary Public

Seal/Stamp

OR

Statement of Witnesses

By signing, I affirm that _____
Name of Person

and the other witness listed, signed this form while I watched. I also affirm that:

- I know them or they could prove who they are
- I am 18 years or older
- I am not their Health Care Agent
- I am not their health care provider
- I do not work for their health care provider

One witness must also affirm that:

- I am not related to them by blood, marriage, or adoption

Witness #1 (Sign your name at the X and write the date below):

X _____ _____/_____/_____
Sign your name Date

_____
Print your name

_____
Address City State Zip Code

Witness #2 (Sign your name at the X and write the date below):

X _____ _____/_____/_____
Sign your name Date

_____
Print your name

_____
Address City State Zip Code

Initials _____
Date _____