THE POCKET LAWYER®
Document Preparation Service
Workbook

"We Help You Help Yourself"

ADVANCE HEALTH CARE DIRECTIVE
(LIVING WILL)

PART "A"

THE POCKET LAWYER®

Document Preparation Service Workbook

"Self-Help" Series

This Workbook is a self-help information product for the preparation of legal and business documents. It is not intended to serve as legal advice or as a substitute for legal advice. We strongly recommend that whenever possible, you seek the advice of a licensed attorney.

Our liability is limited to the refund of the list price or the purchase price, whichever is less.

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Advance Health Care Directive Client Questionnaire

INSTRUCTIONS: Answer All questions with an answer or a N/A. Today's date _____
If more space is needed, use the space below or attach blank pages.

	PERSONAL INFORMATION			
1	First name			
2	Middle name			
3	Last name			
4	Usual Signature			
5	Home address: Street			
6	Apt/Suite			
7	City	County	State	Zip
8	Mailing address (if different) Street/PO			
9	City	County	State	Zip
10	Home phone	Business phone		
11	Social Security number		Birth date	
	DESIGNATION OF AGENT TO MAKE HEALTH CARE DECISIONS (Attorney in Fact)			
12	First name			
13	Middle name			
14	Last name			
15	Home address: Street			
16	Apt/Suite			
17	City		State	Zip
If additional space is needed, number and insert below.				

Advance Health Care Directive (Continued)			
	First Alternate Agent To Make Health Care Decisions		
18	First name		
19	Middle name		
20	Last name		
21	Home address: Street		
22	Apt/Suite		
23	City	State	Zip
	Second Alternate Agent To Make Health Care Decisions		
24	First name		
25	Middle name		
26	Last name		
27	Home address: Street		
28	Apt/Suite		
29	City	State	Zip
	Choose the powers your AGENT has in dealing with your health care decisions:		
30	Authorized to make ALL health care decisions, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.		
31	Authorized to make ALL health care decisions except the following:		
	Choose the Powers your AGENT has in dealing with your medical records:		
32	To receive information regarding my physical and mental health, including access to my medical and hospital records.		
33	To execute releases to obtain medical and hospital records and information.		
34	To consent to the disclosure of this information.		
	Choose the powers your AGENT has in dealing with waivers and releases:		
35	To sign documents entitled “Refusal to permit treatment” and “Leaving hospital against medical advise”, or similar.		
36	To sign any necessary waiver or release from liability required by a hospital or physician.		
	Choose the powers your AGENT has in dealing with the following:		
37	Authorize an autopsy.		
38	Make a disposition of a part or parts of my body as an Anatomical Gift for use in another		

Advance Health Care Directive (Continued)	
39	Make a disposition of a part or parts of my body as an Anatomical Gift for educational or scientific purposes.
40	Direct the disposition of my remains (burial, cremation, etc.)
	Specify the length of this Power of Attorney:
41	Unlimited Duration, until revoked by me at a later date.
42	This Power of Attorney expires on _____. (Fill in date)
	Specify when your AGENT's authority becomes effective:
43	My AGENT's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.
44	My AGENT's authority to make health care decisions for me takes effect immediately.
	Desires Regarding Life Sustaining Treatment
45	Choose ONE of the following paragraphs; 46, 47, 48 or 49. If 46 is selected, mark each sub-paragraph that applies.
46	Choose all that apply: I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if I have an incurable and irreversible condition that will result in my death within a relatively short time I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness I do <u>not</u> want my life to be prolonged and I do <u>not</u> want life-sustaining treatments if the risks and burdens of treatment would outweigh the expected benefits I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.
47	I want my life to be prolonged as long as possible within the limits of generally accepted health care standards, even though the burdens of the treatment outweigh the expected benefits.
48	I do not want any medical treatment except what is necessary to provide feeding and hydration and what is necessary to relieve pain and discomfort.
49	I do not want any medical treatment (including artificial feeding and hydration), except what is necessary to relieve pain and discomfort.
50	I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatments.
51	In addition to the above, I want: (If you have additional desires, complete in your own words)

Advance Health Care Directive (Continued)	
If additional space is needed, number and insert below.	
	DONATION OF ORGANS AT DEATH
52	Upon my death, I do NOT wish to donate my organs.
53	Upon my death, I give any needed organs, tissues, or parts.
54	Upon my death, I give the following organs, tissues, or parts only:
55	My anatomical gift is for the following purposes: (select ALL that apply) Transplant Therapy Research Education
	FINAL REQUESTS
56	Final Arrangements (Choose ALL that apply):
57	I want to be cremated at: (Location)
58	I want to be buried at: (Location)
58	I want to be embalmed
60	Location of burial site:
61	Type of casket:
62	Type of marker:
63	Epitaph:
64	Flowers YES NO
65	Type of ceremony and size:

Advance Health Care Directive (Continued)	
	PRIMARY PHYSICIAN
66	I designate the following physician as my primary physician: Name Address City, State, Zip Phone
67	I f the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician: Name Address City, State, Zip Phone
If additional space is needed, number and insert below.	
	OTHER WISHES

I (We), acknowledge that the information provided by me in this Workbook is true and accurate to the best of my knowledge. I further acknowledge that I am going to do my own Advance Health Care Directive and want the **POCKET LAWYER**® Document Preparation Service to assist me by performing certain document preparation services, according to my instructions. I will be solely responsible for the information contained in these documents and will have the opportunity to review the completed documents before they are filed. I understand that the **POCKET LAWYER** Document Preparation Service does not render legal advice or legal services and is acting solely at my direction and pursuant to my decisions. I further understand that I have the right to handle my own legal matters and act as my own attorney, but that the advice of an attorney may be necessary. The **POCKET LAWYER** encourages attorney participation and will provide a list of attorney referrals, at my request.
I hereby relieve the **POCKET LAWYER** from any liability whatsoever, regarding this advance health care directive matter, and agree to hold them harmless from any damages I may suffer and understand that my sole relief is limited to the return of any fee paid for the preparation of these documents.

Signature	Date
Print name	
Signature	Date
Print name	