My plan

Fill out this brief form, sign it, date it and have two witnesses sign their names and write the date.

1. If I have a life-limiting illness or life-threatening injury, I want the following support treatment (choose ONE that best describes your wishes):
   a. Apply any life support treatments my physician recommends. If the treatments don't work and there's little hope to improve, I want to stay on life support machines and/or medications.
   b. Apply any life support treatments my physician recommends. If the treatments don't work and there's little hope to improve, **I DO NOT** want to stay on life support machines and/or medications.
   c. Apply life support treatments my physician recommends, **EXCEPT** for these:
      - ☐ CPR
      - ☐ Heart machines
      - ☐ Breathing machines
      - ☐ Kidney dialysis
      - ☐ Feeding tube
      - ☐ Blood transfusions
      - ☐ Medications
      - ☐ Other
   d. I want my healthcare agent to make the decisions for me

2. I also want to try to achieve this level of comfort:
   a. Apply whatever it takes to keep me pain-free
   b. Apply what it takes to keep me comfortable but as clear-minded as possible
   c. Apply no medications but try natural remedies and/or massage for pain
   d. Give me no pain medications or treatments – let nature take its course

3. If I can't make or communicate my medical decisions, I want this person to make or communicate the decisions for me:

   Option 1 Name ______________________________
   Address ______________________________
   Phone Number ______________ Email Address ______________

   Option 2 Name ______________________________
   Address ______________________________
   Phone Number ______________ Email Address ______________

4. If possible, I prefer to spend my remaining time at:
   a. Home
   b. Hospital
   c. Inpatient Hospice Unit/Facility (if known, please specify) ______________
   d. Other (please specify) ______________
   e. Not sure

5. If possible, I wish to spend time especially with these people:

____
____
____
____
____

6. I want my family and friends to know:

____
____
____
____
____

____
Signed | Print Name | Date

____
Witness #1 Signature | Print Name | Date

____
Witness #2 Signature | Print Name | Date

For details on sharing and storing your wishes, visit **www.chot.org/whats-your-plan**.

Sponsored by Community Healthcare of Texas. Have questions about documenting your plan, call us at 817.870.2795 or visit CHOT.org.

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