MY ADVANCE CARE PLANNER

You matter; your wishes matter

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The Advance Care Planner helps you share what quality of life means to you and choices to consider if you become very sick and are not able to speak for yourself.

It can provide guidance to your loved ones who may have to make difficult medical decisions for you.

This planner can help you, your family and your medical providers understand your preferences. Once you complete the planner, you can complete the Oregon Advance Directive form. The form allows you to identify who you want making your health care decisions and write down your goals and wishes for your health care.

Recommended steps to complete your Oregon Advance Directive:

1. Read the Explanation Booklet.
2. Read and complete the My Advance Care Planner.
3. Complete the legal Oregon Advance Directive for Health Care form.

If you have questions or need further assistance, you may ask your health care provider or contact the Salem Health Spiritual Care office at 503-561-5562.

- **This planner is NOT your Advance Directive and is NOT a legal document.**
- You must complete the Oregon Advance Directive (included in this packet), which is the *legal* form for the state of Oregon.
- The planner covers in detail parts of the Oregon Advance Directive. The planner can be completed as an addition or substitute for sections 3b through 4b of the Advance Directive form **ONLY IF** you attach the completed planner to your Advance Directive form.
- The planner can be done in addition to those sections, or in place of those sections. Attach the planner to your Advance Directive form and mention it in section 4, part C: "other."

Full name: _____

Date of birth: _____

My Advance Care Planner

Check and/or fill out the options below that match your goals and values. There are no wrong answers.

We hope the statements below help you understand the specific realities you might face if you were very sick, unable to speak for yourself and not likely to recover. Consider what is most important to you in your life. These statements will assist your health care representative and medical team in providing the best care for YOU.

Defining quality of life

If providers involved in my care believed I would be very unlikely to improve from my condition, would I want my life prolonged...

A. COMMUNICATION

If I could not think well enough to make everyday decisions?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not communicate out loud?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not communicate with others by writing?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not have meaningful conversation?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not recognize my family and friends?

☐ Prolong ☐ Not prolong ☐ Not sure

If providers involved in my care believed I would be very unlikely to improve from my condition, would I want my life prolonged...

B. ACTIVITIES OF DAILY LIVING

If I could not walk on my own?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not get up on my own? (getting to and from bed, moving from chair to toilet, etc.)

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not feed myself?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not dress myself?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not bathe myself?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not go to the bathroom on my own?

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not clean my private parts?

☐ Prolong ☐ Not prolong ☐ Not sure

I would NOT want my life prolonged if I could not engage in the following activities:

If providers involved in my care believed I would be very unlikely to improve from my condition, would I want my life prolonged...

C. HOUSING

If I were spending more time in the hospital than at home

☐ Prolong ☐ Not prolong ☐ Not sure

If I could not live on my own and needed to live in a care facility?

☐ Prolong ☐ Not prolong ☐ Not sure

I would be okay living in a care facility for:

☐ Days ☐ Weeks ☐ Months

☐ Greater than 6 months ☐ Years ☐ The rest of my life

Religion/spirituality/faith

The religious tradition and/or spiritual community that I identify with is (denomination, spiritual practice, etc.) _____

_____

Contact information for specific community: _____

_____

When caring for me, it is important you know my religious/spiritual/faith practices, which are:

_____

_____

The values and beliefs that guide my decisions are: _____

_____

Culture

Culturally, I identify as _____

_____

When caring for me, it is important you know my cultural beliefs/practices, which are:

_____

_____

End-of-life wishes

At the end of my life, before I die, I want...

Those who are important to me at my bedside.

☐ Yes ☐ No ☐ Not sure

If yes, I would like these people at my bedside: _____

_____

Music playing.

☐ Yes ☐ No ☐ Not sure

My favorite music is: _____

My favorite items, which are: _____

_____

To prioritize my comfort over prolonging my life OR to prioritize prolonging my life over my comfort. Mark one:

☐ Prioritize my comfort over prolonging my life

☐ Prioritize prolonging my life over my comfort

If I have a choice, I would be open to receiving my end-of-life care (mark all that apply):

☐ At my home ☐ At a care facility ☐ At a hospital

☐ Other: _____

_____

After I die

After my death, I want...

To be buried.

☐ Yes ☐ No ☐ Not sure

Where: _____

To be cremated.

☐ Yes ☐ No ☐ Not sure

What I would like to be done with my ashes: _____

_____

My chosen funeral home is: _____

Contact information: _____

_____

After my death, I want...

ORGAN DONATION

My organs, eyes, and/or tissue to be donated for the purpose of saving lives and improving the health of others.

☐ Yes ☐ No ☐ Not sure

If you are interested in donation organs when you die, you can declare your donor status when getting or renewing your driver's license and by registering through the donor registry found at Donate Life Northwest **(donatelifenw.org)**.

BODY DONATION

My body to be donated to science.

☐ Yes ☐ No ☐ Not sure

If you are interested in donating your body to science when you die, you can learn more at:

OHSU Body Donation Program
ohsu.edu/body-donation

Western University of Health and Sciences Body Donation Program
westernu.edu/body-donation-program

Educational Body Donation
educationalbodydonation.org

SIGNATURE

I have completed this planner by sharing my final health care wishes, and I want my health care representative(s) to consider these wishes when making my medical decisions.

Signature: _____

Date completed: _____

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