Letter of Instruction
To My Health Care Agent

In order to assist my Health Care Agent, in making health care decisions for me as easily and confidently as possible, I,_____, leave these specific instructions to be consulted along with the directions in my Health Care Power of Attorney.

Instructions for Health Care Providers

I have carefully selected the individual(s) I wish to make medical decisions for me in the event of my incapacity. It is my firm belief that these individuals are best positioned to make such decisions on my behalf. I consider my healthcare a personal and private matter. I do not wish to have other individuals or organizations involved in my healthcare decision-making unless specified in these instructions.

Instructions for Family Members

I have named a Health Care Agent on the advice of counsel. The intent of naming my agent was to send a clear signal to my healthcare providers regarding my wishes and to avoid conflict among my family and others concerned with my healthcare. I do not wish the appointment of my Health Care Agent to be perceived as an expression of distrust or a lesser level of confidence in other family members.

With regard to the termination of life support treatment and other critical or emergency situations, I hereby authorize my Health Care Agent:

YES ☐ **NO** ☐ to consult to the fullest extent possible, with all members of my immediate family regarding my healthcare decisions, particularly those *concerning withholding or withdrawal of treatment should I be in a terminal or irreversible condition.*

YES ☐ **NO** ☐ to hold a conference with all willing and interested members of my immediate family prior to making any decision *regarding termination of artificial life support systems.*

YES **NO**

☐ ☐ to consult the following individual(s) regarding termination of artificial life support treatments:

- ☐ religious clergy:_____
- ☐ medical professional:_____
- ☐ other:_____

I direct that my Health Care Agent consider the following concerns prior to making any decisions regarding termination of artificial life support treatments:

_____

_____

_____

_____

_____

_____

_____

Instructions For My Health Care Agent

The following instructions provide you with guidelines regarding my wishes on the healthcare topics of my *medical records*, *choice of physicians*, *medical tests*, *medications*, and my preferences about *healthcare facilities* and *long-term care*.

If I am unable to act on my behalf, give direction, or consent, please use these guidelines in making wise decisions about my healthcare. You should not feel guilty or anxious about authorizing a course of action because these are the decisions I would make if I were able to do so myself.

I realize that these instructions will not cover every medical situation that may arise, but it is my hope that these instructions will provide you with insight as to the actions I would have taken if I was able to make that choice for myself.

Medical Records

With regard to my medical records, I hereby authorize my Health Care Agent:

YES ☐ **NO** ☐ to obtain and use my medical records during any time when my Health Care Agent is making medical decisions for me.

YES ☐ **NO** ☐ to take my medical records to another physician to obtain a second opinion before making a medical decision for me.

YES ☐ **NO** ☐ to share the information in my medical records with all the members of my immediate family. *I am more concerned with consulting my loved ones that with the issue of privacy.*

I direct that my Health Care Agent consider the following concerns prior to making any decisions **regarding my medical records**:

_____

_____

_____

Choice Of Physicians

With regard to my choice of doctors, I hereby direct my Health Care Agent:

YES ☐ **NO** ☐ to maintain and continue the relationship with my primary care physician for as long as possible.

YES ☐ **NO** ☐ to obtain a referral for a quality specialist if my primary care physician is unable to provide medical treatment for any reason.

YES ☐ **NO** ☐ to seek treatment for me with a specialist in the area of my medical condition, whenever economically feasible.

I direct that my Health Care Agent consider the following concerns prior to making any decisions **regarding my physicians**:

_____

_____

_____

_____

Medical Tests

With regard to the performing of medical tests, I hereby authorize my Health Care Agent:

YES NO UNDECIDED

☐ ☐ ☐ to allow any tests to be performed on me, even if after consultation with my attending physician and any appropriate specialists, the suggested test results are **not** reasonably certain to be beneficial in restoring my health.

YES NO UNDECIDED

☐ ☐ ☐ to obtain second opinions from appropriate specialists, if economically feasible, before authorizing or not authorizing any testing which my attending physician and/or primary care physician believes would be beneficial in restoring my health.

I direct that my Health Care Agent consider the following concerns prior to making any decisions **regarding medical tests**:

_____

_____

_____

_____

Medications

With regard to the use of medications, I hereby authorize my Health Care Agent:

YES NO UNDECIDED

☐ ☐ ☐ to consent to medication to relieve my pain, *if my primary care physician and any appropriate specialists agree that the pain medication would not complicate or worsen my condition*.

YES NO UNDECIDED

☐ ☐ ☐ to use unconventional or experimental medication or therapy in my treatment

YES NO UNDECIDED

☐ ☐ ☐ to consider any possible side effects associated with unconventional or experimental medication or therapy. *I specifically do not want a "cure" that is worse than the original illness.*

YES NO UNDECIDED

☐ ☐ ☐ to balance the cost of unconventional or experimental medication with the expected relief. *I am concerned about the high costs often associated with these types of treatments*.

I direct that my Health Care Agent consider the following concerns prior to making any decisions **regarding medications**:

_____

_____

_____

_____

Healthcare Facility And Long-Term Care Preference

With regard to health care facilities and long-term care, I hereby authorize my Health Care Agent to consider the following preferences:

My preference is to maintain my current independent lifestyle for as long as possible. When I can no longer lead an independent lifestyle:

YES ☐ **NO** ☐ *My first choice is to remain in my home utilizing home-assistance services provided by an outside agency or a family member*. (I realize that there may come a time when my desire to remain in my home may burden my loved ones' lives.)

YES ☐ **NO** ☐ *My first choice is to reside with a family member who is able and willing to take care of me in their home*. (I realize that there may come a time when residing with my family member may burden my loved one's life.)

YES ☐ **NO** ☐ I do not wish to burden my family members with my healthcare needs. When I can no longer maintain my independent lifestyle, with occasional assistance from outside agencies or a family member, *I wish to move to a long-term care facility which can provide me with the appropriate level of care.*

Home Care

YES ☐ **NO** ☐ I encourage my Health Care Agent to investigate and obtain home-assistance services from any or all of the following organizations: Visiting Nurses Association, Home Hospice Healthcare, Meals-On-Wheels, and any other group that provides home assistance services

YES ☐ **NO** ☐ **N/A** ☐ When a family member resides with me and provides the services necessary for me to remain in my home, I direct that no room or board fees be charged to this family member.

YES NO N/A

☐ ☐ ☐ During any time when a family member resides with me and provides the services necessary for me to remain in my home, I direct my Health Care Agent visit my home:

- ☐ at least every week
- ☐ once every two weeks
- ☐ other time frame: _____

to determine that the level of care I am receiving is appropriate.

YES NO

☐ ☐ If my home cannot be used for any reason for home-assistance services provided by an outside agency or a family member, I direct my Health Care Agent to determine if a family member is able and willing to take care of me in their home.

YES NO N/A

☐ ☐ ☐ During any time when a family member provides home-assistance services to me and I reside with that family member in their home, I direct my Health Care Agent visit the home:

- ☐ at least every week
- ☐ once every two weeks
- ☐ other time frame: _____

to review the level of care I am receiving.

YES NO

☐ ☐ During any time when my Health Care Agent believes that I can no longer receive appropriate care in my home or in a family member's home, I authorize my Health Care Agent to select for me and admit me into a nursing care facility.

I direct that my Health Care Agent consider the following concerns prior to making any decisions **regarding care in my home and/or care in my family member's home**:

_____

_____

Institutional Care

YES **NO**

☐ ☐ If I must reside at a long-term care facility, to the extent it is feasible and medically advantageous, I would prefer to reside in an assisted-living facility until I require custodial care.

YES **NO** **N/A**

☐ ☐ ☐ If I must reside at a long-term care or assisted-living facility, to the extent it is economically feasible and medically advantageous, I direct my Health Care Agent to select the following facility:

_____

_____

YES **NO** **N/A**

☐ ☐ ☐ If the above facility is not available or advisable in my Health Care Agent's sole discretion, my Health Care Agent should select a similar institution with the following qualities:

_____

_____

_____

When selecting a long-term care facility, I direct my Health Care Agent to consider ***first:***

☐ facilities located in the community where I live.

☐ facilities that are located in the community where a majority of my family live

☐ other considerations:_____

YES NO

☐ ☐ When selecting a long-term care facility, I request that my Health Care Agent consult my family members to select a facility where my family members would feel comfortable visiting me.

YES NO

☐ ☐ I would prefer, if possible, a long-term care facility which is operated in accordance with my religious beliefs.

YES NO

☐ ☐ I qualify for admission to the following nursing care facilities:_____

_____

YES NO

☐ ☐ I direct that my Health Care Agent make at least two unannounced visits to any prospective nursing care facilities to determine if the services provided are acceptable.

YES NO

☐ ☐ My Health Care Agent shall consider the following factors: the credentials and abilities of care givers; the variety and nutritional value of meals; the type and frequency of recreational activities; the cleanliness of the facility; the frequency of visitors to the facility; and any other services my Health Care Agent shall determine important in the selection of a quality nursing care facility.

YES NO

☐ ☐ During any time when I live in a nursing care facility, I direct that my Health Care Agent visit me

- ☐ at least every week
- ☐ once every two weeks
- ☐ other time frame: _____

to determine that the level of care I am receiving is appropriate.

I direct that my Health Care Agent consider the following concerns prior to making any decisions **regarding institutional care**:

_____

_____

_____

_____

I have consulted with legal counsel, am fully informed as to all the contents of this document, and understand the full import of the grant of these instructions to the persons named as agents in my Health Care Power of Attorney.

I have hereunto set my hand this _____ day of _____,20_____.

_____ _____

Declarant Print Name

Letter Of Instruction
To My Health Care Agent

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YES NO N/A

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- ☐ at least every week
- ☐ once every two weeks
- ☐ other time frame: _____

to determine that the level of care I am receiving is appropriate.

YES NO

☐ ☐ If my home cannot be used for any reason for home-assistance services provided by an outside agency or a family member, I direct my Health Care Agent to determine if a family member is able and willing to take care of me in their home.

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Institutional Care

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YES **NO** **N/A**

☐ ☐ ☐ If I must reside at a long-term care or assisted-living facility, to the extent it is economically feasible and medically advantageous, I direct my Health Care Agent to select the following facility:

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YES **NO** **N/A**

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☐ facilities that are located in the community where a majority of my family live

☐ other considerations:_____

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☐ ☐ When selecting a long-term care facility, I request that my Health Care Agent consult my family members to select a facility where my family members would feel comfortable visiting me.

YES NO

☐ ☐ I would prefer, if possible, a long-term care facility which is operated in accordance with my religious beliefs.

YES NO

☐ ☐ I qualify for admission to the following nursing care facilities:_____

_____

YES NO

☐ ☐ I direct that my Health Care Agent make at least two unannounced visits to any prospective nursing care facilities to determine if the services provided are acceptable.

YES NO

☐ ☐ My Health Care Agent shall consider the following factors: the credentials and abilities of care givers; the variety and nutritional value of meals; the type and frequency of recreational activities; the cleanliness of the facility; the frequency of visitors to the facility; and any other services my Health Care Agent shall determine important in the selection of a quality nursing care facility.

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I direct that my Health Care Agent consider the following concerns prior to making any decisions **regarding institutional care**:

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I have consulted with legal counsel, am fully informed as to all the contents of this document, and understand the full import of the grant of these instructions to the persons named as agents in my Health Care Power of Attorney.

I have hereunto set my hand this _____ day of _____,20_____.

_____ _____

Declarant Signature Print Name