**Optional Attachment to the**

# 4-NEEDS ADVANCE MEDICAL DIRECTIVE ®

**OF**

# Type Client Name Here

INCLUDES: SUPPLEMENT TO LONG-TERM CARE DIRECTIVE®, DEMENTIA DIRECTIVE, AND LEGACY LETTER

## ADDITIONAL MEDICAL INFORMATION

| Medication | Reason for Taking | Would You Want to Continue this Medication if you were in a Nursing Home for Long-Term Care? |
|---|---|---|
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |
| | | ☐ Yes ☐ No ☐ Not sure |

**Allergies and Sensitivities.** If desired, please list all allergies and sensitivities, naming the drug, food, substance, odor, or chemical that you're allergic or sensitive to and describing the reaction and degree of severity you experience:

| Allergy or Sensitivity | Reaction | Degree of severity |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medical Conditions.** To the extent desired, please describe your medical/surgical conditions (including, if desired, eye conditions, dental conditions, psychological conditions, etc.):

| Condition | Dates | Treating Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

# LONG-TERM CARE DIRECTIVE® - ADDITIONAL INFORMATION

## HYPOTHETICAL LONG-TERM CARE SCENARIOS:

**1.** Dementia and Artificial Nutrition/Hydration. You are in a nursing home with Alzheimer's disease or another type of dementia that has progressed to the point where you do not recognize your loved ones and you are no longer able to feed yourself.

a. Would you want to be spoon-fed? ❒ Yes ❒ No ❒ Uncertain

b. If spoon-feeding is not possible, would you want food & liquid by nasogastric tube (i.e. through the nose)? ❒ Yes ❒ No ❒ Uncertain

c. If spoon-feeding is not possible, would you want food & liquid by gastric tube (i.e. through abdomen)? ❒ Yes ❒ No ❒ Uncertain

**2.** Dementia and Recurring Bouts of Pneumonia. You are living in a nursing home and have moderate to late-stage dementia causing mental confusion, but about half the time you recognize and interact with friends and loved ones on a simple level. Physically, you are very frail and need help with most daily activities such as bathing, eating, and toileting. In addition, you have had several bouts of pneumonia in the past year, each time causing you to be hospitalized for several days. In the hospital, you receive breathing support through a respirator and antibiotics through an intravenous tube until you are well enough to be returned to the nursing home. The next time you get pneumonia, do you want respiratory support and antibiotic treatment, or do you want comfort care only?

❒ Respiratory Support and Antibiotic treatment ❒ Comfort care only ❒ Uncertain

**3.** Stroke and Risk of Aspiration Pneumonia. You are living in a nursing home and have had a moderate to severe stroke causing mental confusion, difficulty with speech, and difficulty swallowing. Because of your difficulty swallowing, you are at a risk for developing aspiration pneumonia, so your speech therapist has recommended a diet of only pureed food and thickened liquids. Would you accept this recommendation and eat only pureed food and thickened liquids, or would you prefer to enjoy a regular diet including solid foods?
❒ Restricted diet ❒ Regular diet despite risk of aspiration pneumonia.

**4.** Cancer Treatment with Very Slight Chance of Success. You have cancer; the treatment recommended by doctors will have severe side effects such as pain, nausea, vomiting, weakness, and fatigue, all of which could last for months, and the treatment has a very low chance of success.

*a.* Endure side effects regardless of the low chance of success? ❒ Yes ❒ No ❒ Uncertain

*b.* Endure side effects if your chance of success is less than 25%? ❒ Yes ❒ No ❒ Uncertain

*c.* Endure side effects if your chance of success is less than 10%? ❒ Yes ❒ No ❒ Uncertain

**5.** Cancer Treatment and Terminal Condition. You have terminal cancer. The treatment recommended by doctors has severe side effects such as pain, nausea, vomiting, and weakness, that could last for months, and the therapy is likely to extend your life less than a year. Would you want the treatment?

❒ Yes ❒ No ❒ Uncertain

**6.** Alternative Cancer Therapies. Your oncologist has told you that your cancer is terminal, and says "traditional" treatment might be successful in extending your life, but with severe side effects that might cause suffering and hasten your death. Alternative cancer treatments and protocols that are not FDA-approved might lead to a cure or remission of your cancer. Would you want to forego chemotherapy and/or radiation and instead have your agent research and explore appropriate alternative cancer treatments and protocols?

❒ Yes ❒ No ❒ Uncertain

# DIETARY PREFERENCES:

***DIETARY RESTRICTIONS*** **– please list any dietary restrictions / sensitivities / intolerance, such as intolerance or sensitivity to gluten, dairy, caffeine, eggs, peanuts, tree nuts, soy, seafood, shellfish, sulfites, fructose, aspartame, MSG, onions and scallions, cilantro, food colorings, yeast, sugar alcohols, salicylates, amines; please also explain the symptoms of any such sensitivity or intolerance (e.g., does the food cause diarrhea, bloating, skin rashes, skin flushing, headache, nausea, fatigue, abdominal pain, runny nose, acid reflux, etc.):**

***DIETARY DESIRES*** **– please list any dietary desires, such as your desire to eat a low-carb diet, low-fat diet, low-salt diet, high-salt diet, paleo diet, Mediterranean diet, or "See Food" Diet (meaning if you see a type of food you like, you want to be able to eat it without regard to any potential adverse undesirable or medical consequences):**

***DIETARY HABITS*** **– please indicate any important dietary habits you have, such as drinking coffee or tea every morning, including all details important to you, such as what flavor of coffee or type of tea, what type of creamer and sweetener you prefer, if any, and how many ounces you drink and at what time(s):**

***MEAL PREFERENCES*** **– please indicate how many meals you prefer to eat each day, and at what time(s), and whether you have specific preferences for certain types of foods at certain meals, for example cereal or donuts at breakfast, a cold sandwich or hot food at lunch, etc.:**

***SPECIFIC FOOD PREFERENCES*** **– please list any specific foods or dishes that you like to eat as often as reasonably possible:**

***SPECIFIC FOOD DISLIKES*** **– please list any specific foods or dishes that you always want to avoid:**

***SPECIFIC BEVERAGE PREFERENCES*** **– please list any specific beverages that you like to drink as often as reasonably possible:**

***SPECIFIC BEVERAGE DISLIKES*** **– please list any specific beverages that you always want to avoid:**

# GROOMING AND HYGIENE PREFERENCES:

---------- *BATHING AND SHOWERING* ----------

**Do you prefer to bathe or shower? ❒ Bathe ❒ Shower ❒ Both**

**What type of washing implements do you use in the shower? ❒ Washcloth ❒ Loofah ❒ Loofah on a stick ❒ Natural sponge ❒ Natural sponge on a stick ❒ Plastic scrunchie ❒ Plastic scrunchie on a stick ❒ Other (please describe: (_____)**

**What type of soap do you prefer? ❒ Bar soap ❒ Liquid soap ❒ Foam soap**
**Please specify if you prefer a certain brand and/or type: _____**

**What type of shampoo do you prefer? ❒ Bar soap ❒ Liquid soap ❒ Foam soap**
**Please specify if you prefer a certain brand and/or type: _____**

**Do you use hair conditioner? ❒ Yes ❒ No**
**Please specify if you prefer a certain brand and/or type: _____**

**Do you use body lotion? ❒ Yes ❒ No**
**Please specify if you prefer a certain brand and/or type: _____**

**Do you use hand lotion? ❒ Yes ❒ No**
**Please specify if you prefer a certain brand and/or type: _____**

**Do you use underarm deodorant? ❒ Yes ❒ No**
**Do you use underarm antiperspirant with aluminum chloride? ❒ Yes ❒ No**
**Please specify if you prefer a certain brand and/or type: _____**

**Do you shave? ❒ Yes ❒ No**
**Do you prefer a manual blade or electric shaver? ❒ Manual blade ❒ Electric shaver**
**Please specify if you prefer a certain brand and/or type: _____**
**Please specify the areas of your body you shave, and how often: _____**
_____
_____

---------- *LIP MOISTURIZER* ----------

**Do you regularly feel like you have dry lips? ❒ Yes ❒ No**

**Do you regularly apply some type of lip moisturizer? ❒ Yes ❒ No**
**If yes, please specify if you prefer a certain brand and/or type: _____**
**If yes, please specify how often you re-apply lip moisturizer: _____**

## *TEETH CLEANING*

**How many times a day do you prefer to brush your teeth?** ❒ Once ❒ Twice ❒ Situational

**What type of toothpaste do you prefer?** ❒ Standard Paste ❒ Gel ❒ Combo paste/gel

**What flavor toothpaste do you prefer?** ❒ Peppermint ❒ Spearmint ❒ Cinnamon ❒ Other: _____

**Do you prefer whitening toothpaste?** ❒ Yes ❒ No

**Do you prefer toothpaste with or without fluoride?** ❒ With fluoride ❒ Without fluoride

**Do you desire to floss regularly?** ❒ Yes ❒ No

**Do you use mouthwash or mouth rinse?** ❒ Yes ❒ No
**If yes, which do you prefer:** ❒ Gargling ❒ Oral mist ❒ Dissolvable strips?
**If yes, do you prefer it with or without alcohol?** ❒ With alcohol ❒ Without alcohol
**If yes, please indicate desired taste:** ❒ Original ❒ Light Mint ❒ Citrus ❒ Vanilla Mint

## *USE AND CLEANING OF DENTURES*

**If you have dentures, what cleaning product do you prefer?** _____

**If you have dentures, what gripping product do you prefer?** _____

## *SLEEPING COMFORT PREFERENCES*

**What sleeping position do you prefer to start out in?** ❒ Back ❒ Right Side ❒ Left Side ❒ Stomach

**How many pillows do you like under your head?** ❒ 1 ❒ 2 ❒ 3 ❒ 4

**What type of pillow do you prefer:** ❒ Down ❒ Feather ❒ Polyester ❒ High-density foam ❒ Medium-density foam ❒ Light-density foam ❒ Other: _____

**What thickness of pillow do you prefer:** ❒ Thick ❒ Medium ❒ Thin

**If you sleep on your back, do you like a firm pillow under your knees?** ❒ Yes ❒ No

**If you sleep on your side, do you like a firm pillow between your legs?** ❒ Yes ❒ No

**If you sleep on your side, do you like a full body-length pillow along the front of you?** ❒ Yes ❒ No

**What kind of clothing / pajamas do you like to sleep in (for example, t-shirt, nightgown, flannel pajamas) and does it differ by season?** _____

**What type of blankets / sheets / covering do you prefer (for example, lightweight fuzzy blanket, heavy down comforter, triple sheeting, etc.) and does it differ by season?** _____

**What type of slippers or footwear do you like to keep by your bedside?** _____

**Do you like to have drinking water available on your night stand?** ❒ Yes ❒ No

**If you prefer some other type of drink on your night stand, please indicate:** _____

## PLEASE RATE YOUR LONG-TERM CARE CONCERNS USING THE RATING SCALE BELOW:

| HOW CONCERNED ARE YOU ABOUT . . . | NOT AT ALL CONCERNED | SLIGHTLY CONCERNED | CONCERNED | QUITE CONCERNED | VERY CONCERNED |
|---|---|---|---|---|---|
| **Being free of physical pain?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Losing the ability to think?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Losing your short-term memory?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Losing your long-term memory?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Forgetting the names of your family members?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Forgetting how your family members are related to you?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Forgetting the names of your friends?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being a financial burden on your loved ones?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being a physical burden on your loved ones?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being an emotional burden on your loved ones?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being able to perform your own activities of daily living (bathing, dressing, feeding yourself, remaining continent, using the toilet, getting in and out of a chair or bed)?** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being free from symptoms related to your disease process (nausea, vomiting, diarrhea, shortness of breath, pain, discomfort, etc.)?** | ❒ | ❒ | ❒ | ❒ | ❒ |

# FAVORITES:

**PLEASE INDICATE IF YOU HAVE FAVORITES IN ANY OF THE FOLLOWING CATEGORIES:**

| | |
|---|---|
| **TV CHANNELS:** | |
| **TV SHOWS:** | |
| **TV GENRES:** | |
| **BOOKS / BOOK GENRES:** | |
| **WRITERS:** | |
| **MAGAZINES:** | |
| **FILMS / FILM GENRES:** | |
| **ACTORS:** | |
| **FILM DIRECTORS:** | |
| **MUSIC / MUSIC GENRES:** | |
| **SONGS:** | |
| **MUSICIANS:** | |
| **INSTRUMENT TYPES:** | |
| **ARTISTS / ART GENRE:** | |
| **ARTWORK TYPES:** | |
| **ANIMALS / PETS:** | |
| **COLORS:** | |
| **FLOWERS:** | |
| **PLANTS:** | |

# INTERESTS AND ACTIVITIES:

**PLEASE INDICATE THE FOLLOWING REGARDING YOUR INTERESTS AND ACTIVITIES:**

**Do you prefer to choose your own activities or have others choose for you?**
**❒ Choose my own ❒ Have others choose for me.**

**What sort of social situations do you prefer?**
**❒ Large groups ❒ Small groups ❒ One-on-one ❒ Prefer to be left alone.**

**Do you always feel this way? ❒ Yes ❒ No. Comments:** _____

_____

**Do you enjoy visits from family and friends? ❒ Yes ❒ No**

**If yes, please list below any family and friends that you especially would enjoy visits from:**

| Name | Relationship | Age | Occupation | Cell Phone | Email |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Are there any individuals you wish not to see? ❒ Yes ❒ No**
**If yes, name(s):** _____

_____

**Do you enjoy the company of young children? ❒ Yes ❒ No**

**Comments / Please explain if desired / Is there an age range you prefer or don't prefer?**

_____

**Do you enjoy having your birthday celebrated with family and friends? ❒ Yes ❒ No**

**Do you enjoy birthday activities such as blowing out candles and singing of the "Happy Birthday" song? ❒ Yes ❒ No**

**Do you enjoy celebrating occasions by wearing birthday hats, crowns, beads, or other related items? ❒ Yes ❒ No**

**Do you enjoy arts and crafts? ❒ Yes ❒ No**

**What kinds?** _____

**Do you enjoy crossword puzzles? ❒ Yes ❒ No**

**Do you enjoy word search puzzles? ❒ Yes ❒ No**

**Do you enjoy Sudoku puzzles? ❒ Yes ❒ No**

**Do you enjoy solitaire? ❒ Yes ❒ No**

# DEMENTIA DIRECTIVE

**DEMENTIA is categorized in anywhere from three stages to seven stages, depending on the doctor doing the diagnosis. The three-stage scale is the simplest scale and one of the most common that many doctors use to describe the typical progression of dementia. The three-stage model is characterized by mild dementia (early stage), moderate dementia (middle stage), and severe dementia (late stage). The descriptions of each stage are as follows, though can vary significantly based on the type of dementia. The symptoms below are most associated with Alzheimer's type dementia – the most common form.**

**STAGE 1 (MILD DEMENTIA): Symptoms typically include forgetfulness, losing or misplacing things, difficulty finding the right words, inability to remember recent events in their lives. Routine tasks such as cooking may become difficult. Some tasks can become more dangerous (such as driving). Individuals with early stage dementia may also become easily confused, or show poor judgment with planning and decision-making.**

**STAGE 2 (MODERATE DEMENTIA): Symptoms typically include increased confusion, limited communication skills, limited ability to understand what is going on around you, greater memory loss, worsening judgment, and requiring daily full-time assistance with dressing and sometimes toileting. Symptoms may also include confusion about orientation, such as where you are or what day it is, and difficulty recalling personal information, such as your address and phone number.**

**STAGE 3 (SEVERE DEMENTIA): Symptoms typically inability to recognize loved ones and family members, inability to sleep through the night, incontinence requiring adult diapers, round-the-clock need for supervision and assistance with all daily activities, including bathing and toileting. You may be calm most or all of the time, but some people at this stage experience angry and disruptive behavior, agitation, and sometimes even violent outbursts toward loved ones.**

**PLEASE REFER TO THE ABOVE DESCRIPTIONS WHEN INITIALING YOUR CHOICES IN THE MATRIX BELOW:**

| Please indicate what your wishes would be at each stage of dementia. | My wish would be to live for as long as I could at this stage. I would want full efforts to prolong my life, including efforts to restart my heart if it stops beating. | My wish would be to receive treatments to prolong my life, in a hospital if necessary, but if my heart stops beating or I can't breathe on my own then do not restart my heart and do not place me on a ventilator; allow me to die peacefully with pain relief medication as appropriate. | My wish would be to only receive care where I am living. I would not want to be hospitalized for any reason, even if I were very ill. Do not restart my heart and do not place me on a ventilator; allow me to die peacefully where I live with pain relief medication as appropriate. I do not want to die in a hospital. | My wish would be to receive comfort-care only – care focused on relieving pain, suffering, anxiety, or breathlessness. I would not want any care that would keep me alive longer. |
|---|---|---|---|---|
| **Stage 1** | | | | |
| **Stage 2** | | | | |
| **Stage 3** | | | | |

## LEGACY LETTER TO YOUR FAMILY AND INFO FOR FUTURE CAREGIVERS

**VALUES:**

**PLEASE USE THE RATING CHART BELOW TO INDICATE THE DEGREE TO WHICH YOU VALUE THE FOLLOWING**

| HOW MUCH DO YOU VALUE . . . | DON'T VALUE AT ALL | VALUE SLIGHTLY | VALUE | VALUE QUITE A BIT | VALUE GREATLY |
|---|---|---|---|---|---|
| **Feeling useful and necessary** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Feeling valued** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Living a long life** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Living an active life** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Living a productive life** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being able to live independently** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being able to remain in your current home and age in place** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Spending time with family and friends** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being able to recognize your family and other loved ones** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being able to effectively communicate** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being able to think clearly** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being able to perform your own activities of daily living (bathing, dressing, feeding yourself, remaining continent, using the toilet, getting in and out of a chair or bed)** | ❒ | ❒ | ❒ | ❒ | ❒ |
| **Being free from symptoms related to your disease process (nausea, vomiting, diarrhea, shortness of breath, pain, discomfort, etc.)** | ❒ | ❒ | ❒ | ❒ | ❒ |

**Please list any other things you place a high value in:** _____

_____

_____

**Is there anything you still want to accomplish in your life?** _____

_____

_____

**EDUCATION: Schools you have attended and degrees you have earned that you wish to share or were important to you:** _____

**CAREER / EMPLOYMENT: Employers / positions you wish to have known about you and approximate dates. You may also wish to indicate your level of satisfaction with each position:** _____

**MILITARY SERVICE: Have you ever served in the military?** ☐ **No** ☐ **Yes**

**If yes: Branch of Service?** _____ **From:** _____ **Until:** _____
**Additional information on Military Service (types of duties, etc., satisfaction with this type of work):** _____

**RESIDENCE: Please list, if desired, important places where you have lived along with dates of residence:**

**TRAVEL: Please list, if desired, significant travel you have undertaken, including the dates of each trip and any special memories you have about each travel experience:** _____

**GROUPS: Please list, if desired, organizations to which you have belonged, such as fraternities / sororities, social clubs, civic groups, community and volunteer organizations (including any positions of leadership you held):** _____

**TRADITIONS: Please list, if desired, cultural events, and holidays important in your life (such as Christmas/Hanukkah, Easter/Passover, Halloween, Thanksgiving, 4th of July, Memorial Day, special birthdays, special anniversaries and any additional information you wish to add about each event or tradition):** _____

**MEMORIES: If desired, please describe your fondest memories.** _____

**TURNING POINTS: If desired, please list any experiences in your life that you would describe as turning points.** _____

**ADDITIONAL INFO: If desired, please detail any biographical information about yourself that has not yet been covered:** _____

## ADDITIONAL INFORMATION FOR MY END-OF-LIFE DIRECTIVE

**1.** If you could plan it today, what would the last day or week of your life be like?

Where? In a hospital? A special place? At home? _____

Who should be present? _____

What type of music, if any, should be playing? _____

What would you like to be doing? _____

If you can eat, what would you like to eat? _____

If you are able, what would your last actions be? _____

**2.** At the end of your life, you prefer that:

_____ Your specific preferences are followed, even if there is disagreement among your family or friends.

_____ Your family and friends are all in agreement, even if the course they choose is not your specific preference.

_____ Uncertain

**3.** Your spiritual feelings regarding the end of life:

_____ I have led a good life and am not afraid of death.

_____ I believe that when we die, we cease to exist.

_____ I believe that we are eternal spiritual beings, and that although my body will die, my true self will live on.

_____ I believe that I will be reunited with my loved ones who have departed this earthly existence before me.

_____ Other: _____

Date: _____ _____

Type Client Name Here