

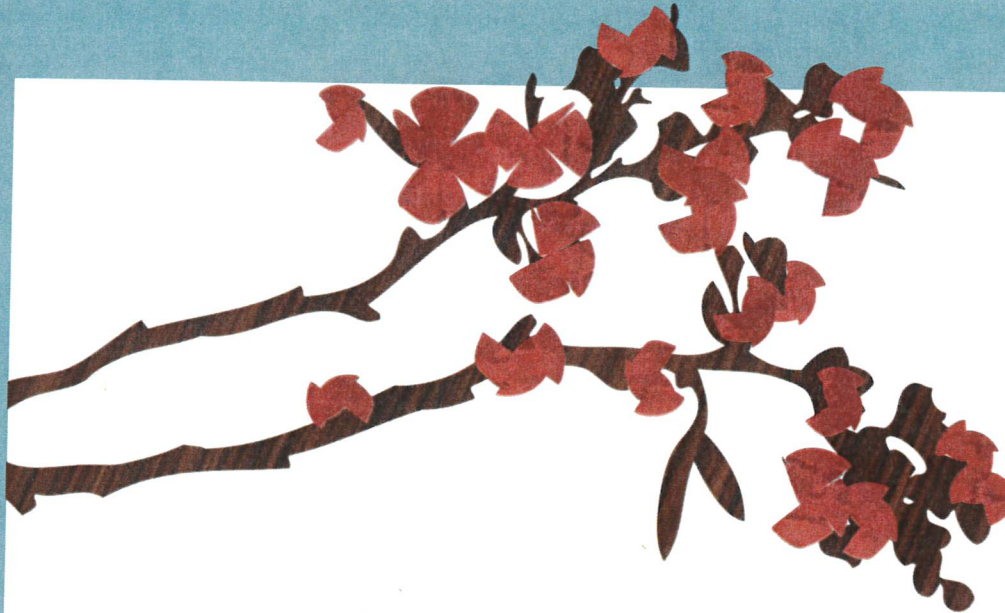
WELCOME  
**ANTIOCH CHURCH**  
BUILDING YOUR LEGACY

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**FEBRUARY 28, 2026**

**9-11AM**

Introduction: Hospice of the Conejo  
Aging in the 80s  
The Power of Choosing How You Want to LIVE  
POLST Form  
Advance Healthcare Directive  
Dementia Questionnaire  
Palliative Care  
Hospice Care  
After Care  
Share Your Life Story



## **HOSPICE OF THE CONEJO**

**HOSPICE OF THE CONEJO WAS FOUNDED IN 1977  
WITH A MISSION:**

**DELIVER NEIGHBORLY SOCIAL AND EMOTIONAL SUPPORT TO  
THOSE FACING LIFE-LIMITING ILLNESSES**

**PROVIDE RESPITE CARE TO FAMILY MEMBERS**

**PROVIDE GRIEF SUPPORT GROUPS FOR THOSE WHO HAVE LOST  
A LOVED ONE**

**LEAD COMMUNITY EDUCATION REGARDING END-OF-LIFE  
OPTIONS**

**OFFER TRUSTED REFERRAL INFORMATION**

**PROVIDE ALL SERVICES FREE OF CHARGE**



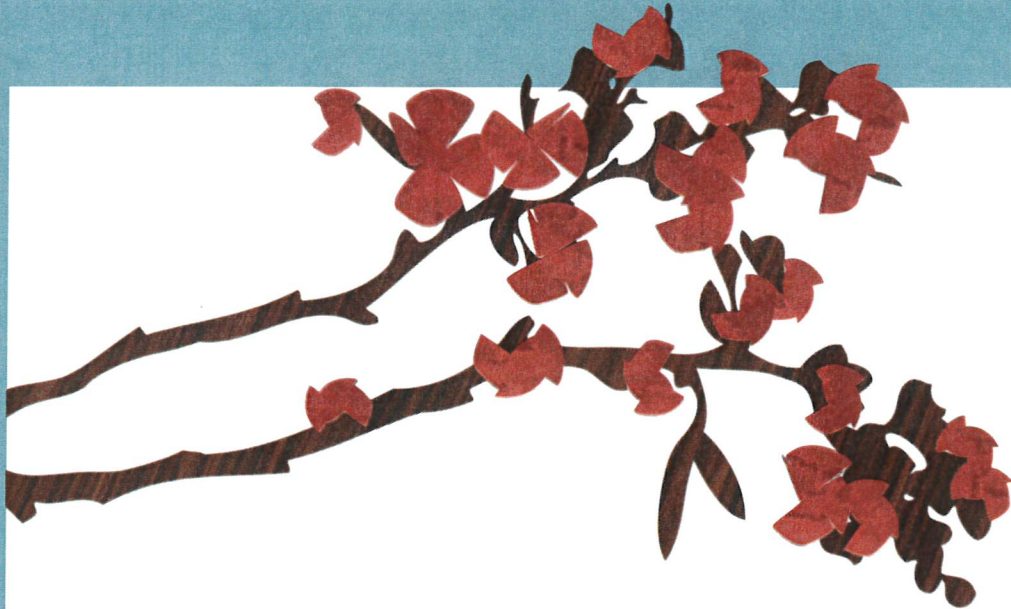
# AGING IN THE 805

**33% OF RESIDENTS 65+ HAVE A DISABILITY**

**22% HAVE DIABETES**

**22% HAVE HEART DISEASE**

**33% HAVE MULTI-GENERATIONAL CAREGIVER BURN-OUT**



## WHERE WOULD YOU LIKE TO LIVE?

HOME – WITH EMPLOYED CARE AS NECESSARY

IN A CLOSE FAMILY MEMBER'S HOME

ASSISTED CARE            \$4,500 TO \$15,000

BOARD AND CARE        \$5,000 TO \$15,000

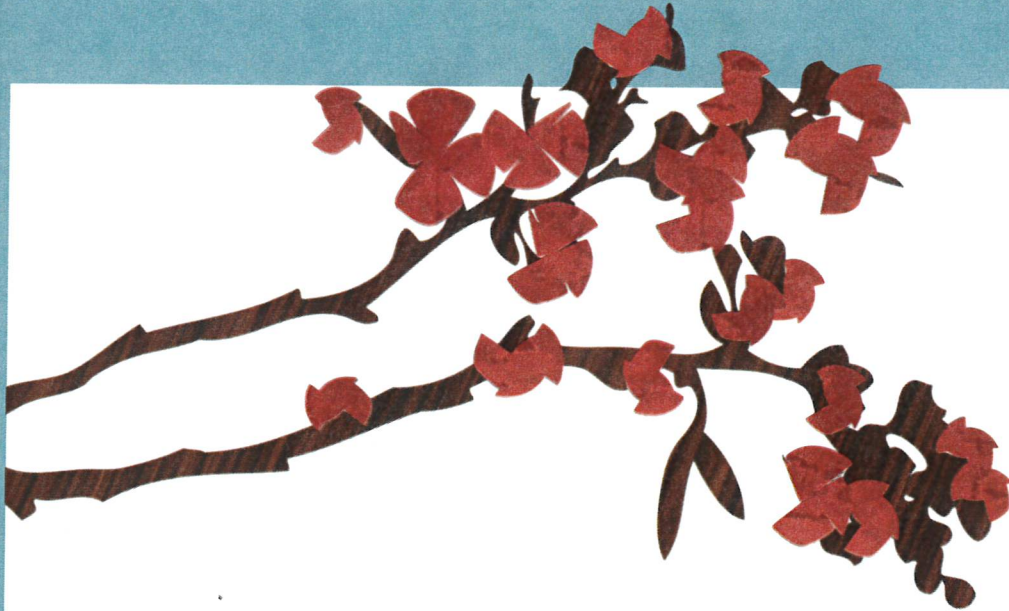
## HOW WOULD YOU LIKE TO LIVE?

INDEPENDENTLY

WITH ASSISTANCE – BASED UPON MY OWN SCALE OF ABILITY

WITH HEROICS – BASED UPON MY WISHES

WITHOUT HEROICS – BASED UPON MY WISHES



**WHERE WOULD YOU LIKE TO DIE?**

**WHO SHOULD BE PRESENT?**

AT HOME

IN A HOSPITAL

IN NATURE

WITH FAMILY AND FRIENDS NEARBY

ALONE



## **POLST FORM**

(PHYSICIAN'S ORDER FOR LIFE SUSTAINING  
TREATMENT)

A DOCTOR'S ORDER FOR YOUR CARE IN CASE OF  
EMERGENCY

FOR ELDERLY, SERIOUSLY ILL, OR ASSISTED  
LIVING RESIDENTS

AVAILABLE TO FIRST RESPONDERS

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**



EMSA #111 B  
(Effective 4/1/2017)\*

**Physician Orders for Life-Sustaining Treatment (POLST)**

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

**A**

Check One

**CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

- Attempt Resuscitation/CPR (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
- Do Not Attempt Resuscitation/DNR (Allow Natural Death)

**B**

Check One

**MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

- Full Treatment** – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - Trial Period of Full Treatment.
- Selective Treatment** – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - Request transfer to hospital only if comfort needs cannot be met in current location.
- Comfort-Focused Treatment** – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: \_\_\_\_\_

**C**

Check One

**ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

- Long-term artificial nutrition, including feeding tubes. Additional Orders: \_\_\_\_\_
- Trial period of artificial nutrition, including feeding tubes. \_\_\_\_\_
- No artificial means of nutrition, including feeding tubes. \_\_\_\_\_

**D**

**INFORMATION AND SIGNATURES:**

Discussed with:  Patient (Patient Has Capacity)  Legally Recognized Decisionmaker

Advance Directive dated \_\_\_\_\_, available and reviewed → Health Care Agent if named in Advance Directive:  
 Advance Directive not available Name: \_\_\_\_\_  
 No Advance Directive Phone: \_\_\_\_\_

**Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)**

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: (required)	Date:	

**Signature of Patient or Legally Recognized Decisionmaker**

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: (write self if patient)
Signature: (required)	Date:
Mailing Address (street/city/state/zip):	Phone Number:

Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**

\*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

# HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

## Patient Information

Name (last, first, middle):	Date of Birth:	Gender: <b>M</b> <b>F</b>
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## NP/PA's Supervising Physician

Name:	Preparer Name (if other than signing Physician/NP/PA) Name/Title:	Phone #:
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## Additional Contact

None

Name:	Relationship to Patient:	Phone #:
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## Directions for Health Care Provider

### Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

### Using POLST

- Any incomplete section of POLST implies full treatment for that section.

#### Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

#### Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

### Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

### Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.  
For more information or a copy of the form, visit [www.caPOLST.org](http://www.caPOLST.org).

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**



## CA ADVANCE HEALTHCARE DIRECTIVE

A LEGAL DOCUMENT WHICH STATES YOUR WISHES AND ASSIGNS YOUR HEALTHCARE AGENT(S)

SELECT THE RIGHT AGENT(S)

MAKE YOUR SPECIFIC WISHES KNOWN

CREATE A MEANINGFUL RECOVERY STATEMENT

***I VALUE A FULL LIFE MORE THAN A LONG LIFE. IF I HAVE LOST THE ABILITY TO INTERACT WITH OTHERS AND HAVE NO REASONABLE CHANCE OF REGAINING THIS ABILITY, OR IF MY SUFFERING IS INTENSE AND IRREVERSIBLE, EVEN THOUGH I HAVE NO TERMINAL ILLNESS, I DO NOT WANT TO HAVE MY LIFE PROLONGED. I WOULD NOT THEN ASK TO BE SUBJECTED TO SURGERY OR TO RESUSCITATION PROCEDURES, TO INTENSIVE CARE SERVICES, OR TO OTHER LIFE-PROLONGING MEASURES, INCLUDING THE ADMINISTRATION OF ANTIBIOTICS, BLOOD PRODUCTS, OR ARTIFICIAL NUTRITION OR HYDRATION. I ALSO BELIEVE THAT THE FINANCIAL AND EMOTIONAL BURDEN ON MY FAMILY SHOULD BE CONSIDERED IN MAKING THESE TYPES OF DECISIONS.***

**Part 1 – Power of Attorney for Health Care**

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

**Designation of Agent:**

I designate the following person as my agent to make health care decisions for me:

Name of person you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
*(home phone)* *(work phone)* *(cell)*

**OPTIONAL:** If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent:

Name of person you choose as alternate agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
*(home phone)* *(work phone)* *(cell)*

**Agent's Authority:**

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Add additional sheets if needed.)*

**When Agent's Authority Becomes Effective:**

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions. \_\_\_\_\_  
(Initial here)

**OR**

My agent's authority to make health care decisions for me takes effect immediately. \_\_\_\_\_  
(Initial here)

**Agent's Obligation:**

My agent must make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**Agent's Postdeath Authority:**

My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

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*(Add additional sheets if needed.)*

**Nomination of Conservator:**

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agent whom I have named.

**Part 2 – Instructions for Health Care**

If you fill out this part of the form, you may strike any wording you do not want.

**End-of-Life Decisions:**

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

**Choice Not To Prolong Life:**

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits. \_\_\_\_\_

*(Initial here)*

**OR**

**Choice To Prolong Life:**

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. \_\_\_\_\_

*(Initial here)*

**Relief From Pain:**

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

\_\_\_\_\_  
\_\_\_\_\_

*(Add additional sheets if needed.)*

**Other Wishes:**

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Add additional sheets if needed.)*

**Part 3 – Donation of Organs, Tissues, and Parts at Death (Optional)**

Upon my death:

I give my organs, tissues, and parts. \_\_\_\_\_  
*(Initial here to indicate yes)*

By initialing this line, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

**OR**

I do *not* authorize the donation of any organs, tissues or parts. \_\_\_\_\_  
*(Initial here)*

**OR**

I give the following organs, tissues, or parts only: \_\_\_\_\_

\_\_\_\_\_  
*(Initial here)*

My donation is for the following purposes (strike any of the following you do not want):

Transplant _____ <i>(Initial here)</i>	Research _____ <i>(Initial here)</i>
Therapy _____ <i>(Initial here)</i>	Education _____ <i>(Initial here)</i>

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines: \_\_\_\_\_

I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.  
 Yes \_\_\_\_\_ *(Initial here)*                      No \_\_\_\_\_ *(Initial here)*
  
2. My donated tissue may be used for applications outside of the United States.  
 Yes \_\_\_\_\_ *(Initial here)*                      No \_\_\_\_\_ *(Initial here)*
  
3. My donated tissue may be used by for-profit tissue processors and distributors.  
 Yes \_\_\_\_\_ *(Initial here)*                      No \_\_\_\_\_ *(Initial here)*

If I leave Part 3 blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or on page 3 of this form.)

**Part 4 – Primary Physician (Optional)**

I designate the following physician as my primary physician:

Name of Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**OPTIONAL:** If 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 of Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

**Part 5 – Signature**

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

**Signature:**

Sign and date the form here:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(patient)

Print name: \_\_\_\_\_  
(patient)

Address: \_\_\_\_\_  
\_\_\_\_\_

**Statement of Witnesses:**

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

**First Witness**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

**Second Witness**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

**Additional Statement of Witnesses:**

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

State of California )  
County of \_\_\_\_\_ )  
\_\_\_\_\_ )

On (date) \_\_\_\_\_ before me, (name and title of the officer) \_\_\_\_\_

\_\_\_\_\_ personally appeared (name(s) of signer(s)) \_\_\_\_\_, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: \_\_\_\_\_ [Seal]  
(notary)

**Part 6 – Special Witness Requirement**

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

**Statement of Patient Advocate or Ombudsman**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

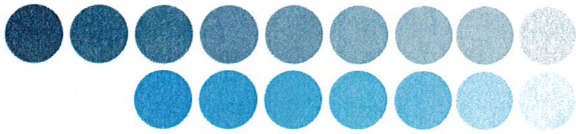
Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(patient advocate or ombudsman)

Print name: \_\_\_\_\_  
(patient advocate or ombudsman)

Address: \_\_\_\_\_

Civil Code Section 1189; Health and Safety Code Section 7158.3; Probate Code Section 4701



## Dementia Advance Directive

I, \_\_\_\_\_ am completing this document because I want my surrogate decision maker(s), physicians and health care team, family, caregivers and loved ones to know my wishes regarding the type of care I want if I am living with dementia.

### Care Preferences

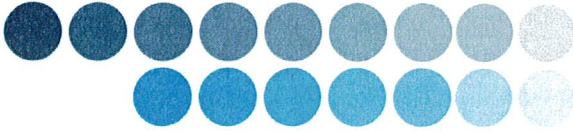
For the questions below, select one of three options to indicate your desired care preferences.

**Live as Long as Possible** - My goal is to live as long as possible and receive aggressive medical care and life-saving treatments. This could include calling 911, going to the hospital, CPR, nutrition support, artificial hydration or breathing assistance if needed.

**Treat me but not Aggressively** - I want to continue medication for chronic health conditions (e.g. diabetes, heart disease) and treatment for illness (e.g. pneumonia and infections). I want to avoid surgery, long-term feeding tubes, aggressive treatment and other life-prolonging care.

**Allow a Natural Death** – Focus on comfort care, avoiding medications and treatments that prolong life. This could include stopping dialysis or blood transfusions, avoiding surgery, turning off a pacemaker or withdrawing treatment for heart disease, diabetes and other health conditions.

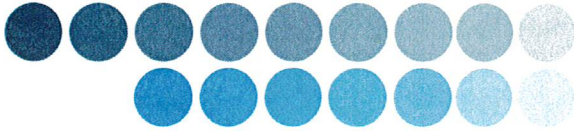
If my physician or health care provider has determined my dementia has progressed to advanced or late stage then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>
If I require around-the-clock (24 hour) assistance and supervision, then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>
If I no longer recognize my loved ones, then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>



If I am unable to walk or move safely without assistance from a caregiver then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>
If I am unable to bathe and clean myself without assistance from a caregiver, then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>
If I am unable to remain at home and have to live in a nursing facility, then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>
If I no longer have control of my bladder (urinary incontinence) or bowels (bowel or fecal incontinence), then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>
If I am no longer aware of my surroundings (where I am, the date/year, who is with me), then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>
If I am unable to clearly communicate my thoughts or needs (words and phrases do not make sense), then I want	Live as Long as Possible <input type="radio"/>	Treat me but Not Aggressively <input type="radio"/>	Allow a Natural Death <input type="radio"/>

### Interest in Hospice Care

If my physician or health care provider determines I have six months or less to live, then	I am interested in Hospice Care to support me and my loved ones. I would like to enroll as soon as I am eligible <input type="radio"/>	I am not interested in hospice <input type="radio"/>	I am unsure at this time. My surrogate can make that decision on my behalf when the time comes <input type="radio"/>
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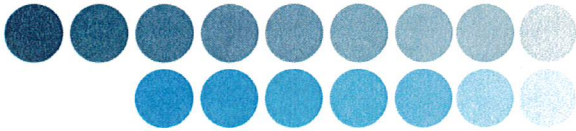


## Food and Drink

<p>If the changes caused by dementia result in any of the following:</p> <ul style="list-style-type: none"><li>• I no longer appear to desire food or drink, turn my head or otherwise avoid being fed or giving fluids</li><li>• I do not open my mouth to accept food or drink without prompting and all food or drink must be provided by a caregiver (hand or spoon-feeding)</li><li>• I am unable to safely swallow food or drink (cough, choke or aspirate/inhale)</li><li>• The negative consequences of continued food or drink as determined by a medical provider, outweigh the benefits</li></ul> <p>Then I request all food and drink be stopped, including nutrition support and hydration</p>	<p>Yes <input type="radio"/></p>	<p>No <input type="radio"/></p>
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## Flexibility for surrogate

<p>This document will help guide my medical team and surrogate decision maker(s). I authorize them to be flexible and make decisions based on what they feel is in my best interest.</p> <p><input type="checkbox"/></p>	<p>This document should serve as clear and precise direction to my medical team and surrogate decision maker(s). My wishes should be followed as much as possible, even if they would personally prefer another option.</p> <p><input type="checkbox"/></p>
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### Additional Information Important to You

For example, do you have additional wishes that were not included? Is there any person you would not want to be consulted about your care? Are you interested in clinical trials (if eligible)? Would you want your representative to advocate for hospice and the possibility of palliative sedation if you are experiencing severe distress or pain?

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### Signature

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Print Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Witness 1

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Witness 2

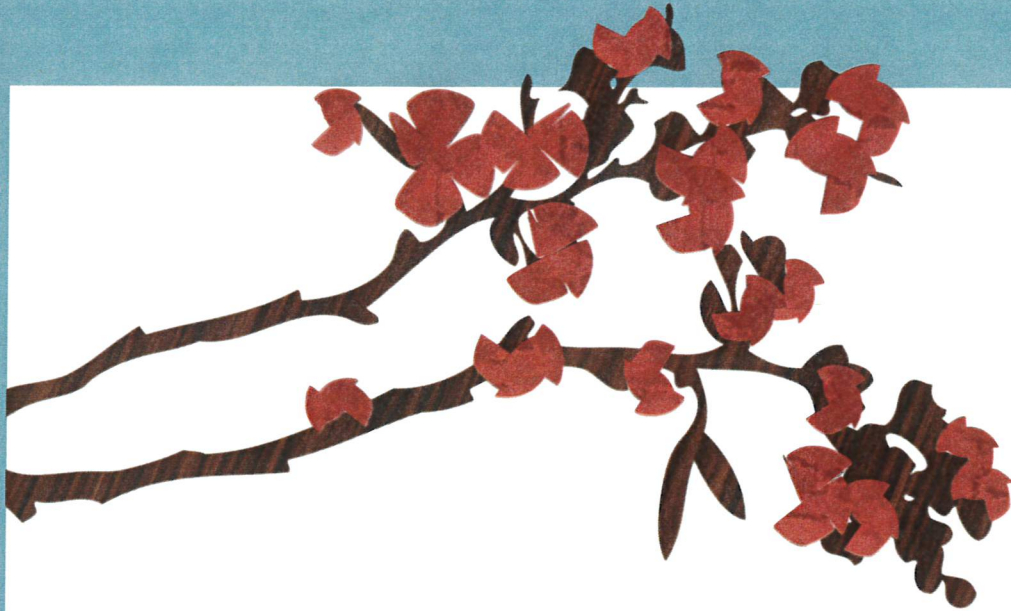
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relation: \_\_\_\_\_

*Signing in the presence of a witness is optional but recommended*



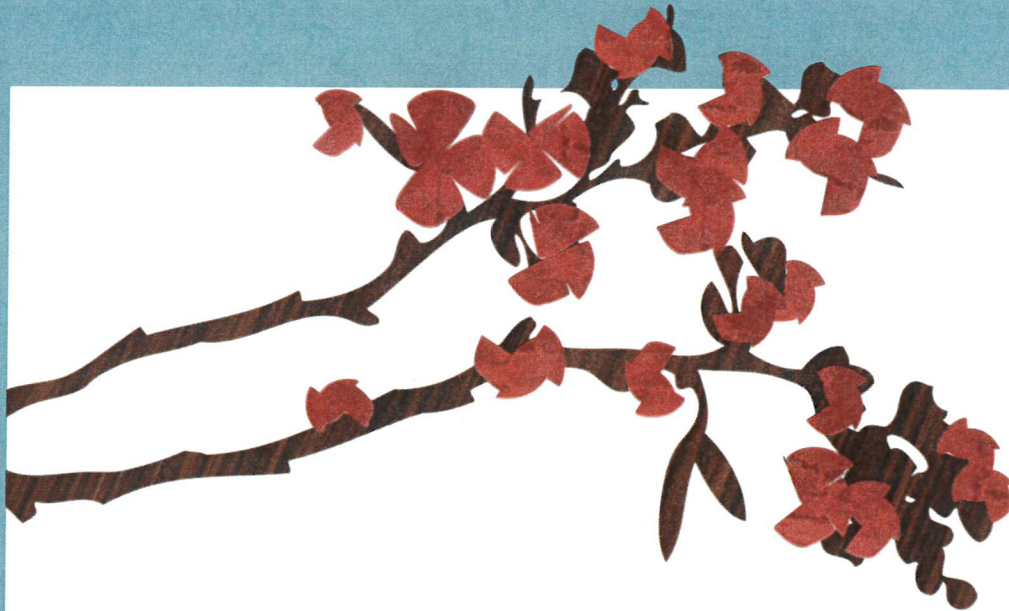
## PALLIATIVE CARE

Provides symptom management for serious illness at any stage, along with curative treatment.

Designed to improve quality of life while pursuing active treatment.

*Betty developed anemia while receiving treatment for breast cancer. The palliative care team suggested a blood transfusion to manage the anemia and relive some of the fatigue being experienced.*

*Controlling her symptoms helped Betty to continue curative chemotherapy treatment. Treating the anemia is part of palliative care.*



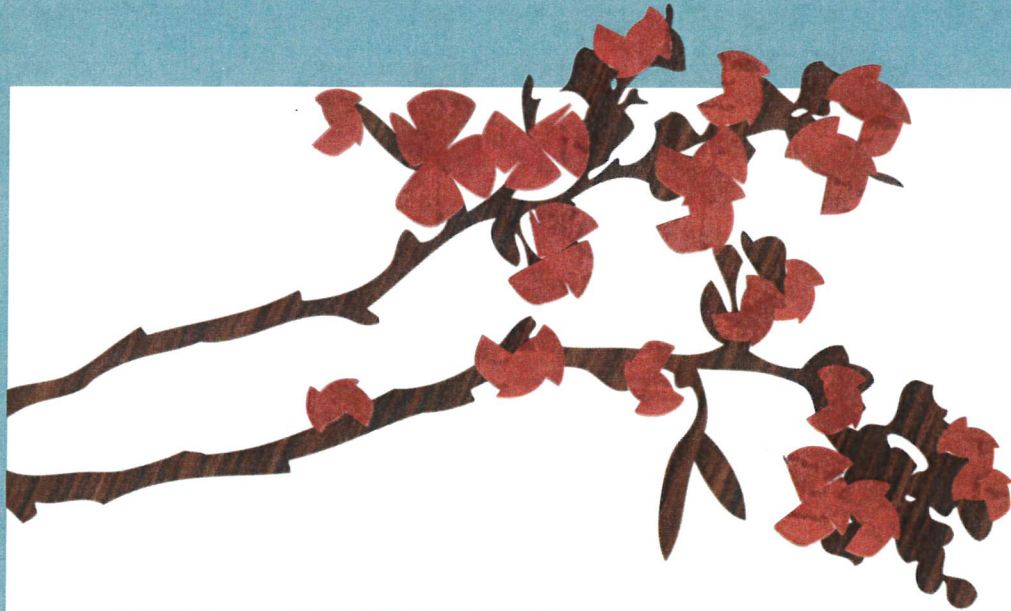
## HOSPICE CARE

Provides comfort care when active treatment has ceased.

Includes symptom management for those with a diagnosis of 6 months or less to live.

Hospice care provides comfort when a cure is no longer possible.

Hospice care is available in the home, nursing home, and under rare circumstances, in the hospital.



## **AFTER CARE OPTIONS**

Direct Cremation: most affordable, skips viewing and funeral

Cremation with Service: viewing, memorial and scattering of ashes

Traditional Casket Burial: embalming, viewing and graveside service

Aquamation (Water Cremation): eco-friendly alternative to flame-based cremation using water and alkaline solution

Natural/Green Burial: environmentally friendly burial without embalming or vaults, using biodegradable materials. Dedicated cemetery, hybrid cemetery, full body burial at sea

Human Composting – becoming available 2027

**Check references! <https://search.dca.ca.gov>**



## **LIFE LEGACY**

**CREATE THE CONVERSATION!**

**SHARE FAMILY HISTORY**

**SHARE OLD PHOTOS AND TELL THE STORIES**

**WHAT HAS BEEN YOUR BIGGEST ACCOMPLISHMENT?**

**WHAT WAS YOUR BIGGEST LESSON?**

**WHAT IS IMPORTANT TO YOU?**

**WHO INFLUENCED YOU?**