Navigating the End of Life - MY WISHES _______________

Name

Take Control of Your Health Care Decisions

Some things in life are out of our hands. You can use this document to make your health care wishes known if you ever become seriously ill. This simple document helps you communicate exactly how you want to be treated. Once signed and witnessed, to include the disclosure page required in Texas, your wishes are officially documented.

What is Navigating the End of Life - My Wishes?

This document is a type of living will (also called an advance directive) that covers more than just medical care. It also includes your personal, emotional, and spiritual needs. It lets you:

- Choose someone to make healthcare decisions for you if you can't.
- Communicate how you want to be treated during serious illness or near the end of life.
- Communicate what matters most to you.

Adapted from the original Five Wishes document, trademarked by a company called Aging with Dignity, this version is condensed, simpler. It's easy to fill out — just check a box, circle a choice, or write a few sentences.

Why This Document is Helpful

- Facilitates important conversations with family, friends, and your doctor.
- Prevents confusion or arguments by clearly outlining your choices.
- Helps you support your loved ones and honor their wishes, too.

Who Should Use It?

Anyone age 18 or older. It's for:

- People who are single, married, parents, or adult children.
- Anyone who wants to make sure their voice is heard — no matter what.

Doctors, hospitals, lawyers, and faith groups often recommend it.

How to Switch to Five Wishes

If you already have another form (like a living will or health care power of attorney), you can switch by:

1. Filling out and signing a Five Wishes form.
2. Destroying your old forms or writing "revoked" on them.
3. Telling your family, doctor, and Health Care Agent about your new wishes.

My Wishes

Wish 1: The Person I Want to Make Health Care Decisions for Me

If I can't make decisions for myself, I choose this person as my **Health Care Agent**:

First Choice:
Name:
Address:
Phone:

Backup Choices:
Second Choice:
Third Choice:

Choose someone who:

- Knows you well
- Can handle tough decisions
- Will respect your wishes
- Is likely to be nearby when needed

They **should NOT be** your doctor, a staff member at your care facility, or someone making decisions for many other people (unless they are a close family member).

My Agent can:

- Approve or refuse treatments
- Hire or fire caregivers
- Make legal decisions
- See medical records
- Apply for benefits like Medicaid
- Donate my organs or tissues (if allowed)

If I want to change this decision later, I'll destroy this form or tell someone and document that it's canceled.

Wish 2: The Medical Treatment I Want or Don't Want

I want to be treated with dignity and kept comfortable. I do **not** want:

- To be in pain
- To have treatments that are only delaying death
- Anything done to intentionally end my life

Life-Support Treatment:

This includes things like breathing machines, CPR, tube feeding, major surgery, dialysis, or antibiotics.

In These Situations, I Want:

If I’m close to death
☐ Keep life support
☐ Stop life support
☐ Try life support, but stop if it’s not working

If I’m in a coma and won’t recover
☐ Keep life support
☐ Stop life support
☐ Try life support, but stop if it’s not working

If I have severe brain damage and won’t recover
☐ Keep life support
☐ Stop life support
☐ Try life support, but stop if it’s not working

Other situation where I don’t want life support:

[Write your example, e.g. “end-stage condition”]

Wish 3: How Comfortable I Want to Be

- Keep me as pain-free as possible, even if it makes me sleepy
- Keep me clean, warm, and dry
- Use cool cloths for fever and moisten my mouth and lips
- Give me baths and massage me with warm oils
- Read spiritual or comforting readings to me
- Help with hospice care if needed

Wish 4: How I Want People to Treat Me

- I want people with me when I may be near death
- Hold my hand and talk to me even if I don't respond
- Let people from my faith community know I'm sick
- Visit me with kindness and joy
- Play my favorite music and display pictures of loved ones
- Call me by this name: **[Your Name]**
- I want to die at home if possible

Wish 5: What I Want My Loved Ones to Know

- I love you
- I forgive you and hope you forgive me
- I'm not afraid of death — I believe it's a new beginning
- I want peace in the family before I die
- Remember me the way I was before I got sick
- Respect my wishes even if you don't agree
- Let this be a time of personal growth for everyone
- Seek counseling if needed

After I die:
I want my body to be: ☐ Buried ☐ Cremated
Location of burial or ashes:

The person who knows my funeral wishes is:
Name:

How I want to be remembered:

[Write what you'd like people to say about you]

Memorial service ideas (songs, readings, etc.):

[Write your requests here]

Other wishes:

[For example: organ donation, charity donations, digital accounts]

Signed ____ Date _______________

Witness # 1 ____ Date ______________
Name

____ Relation ______________
Signature

Witness # 2 ____ Date ______________
Name

____ Relation ______________
Signature

Texas Disclosure Statement

The following statement is required by the Texas Advance Directives Act

This is an important legal document. Before signing this document, you should know these important facts:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

This Power of Attorney is not valid unless it is signed in the presence of two competent adult witnesses. The following persons may not act as ONE of the witnesses:

- the person you have designated as your agent.
- a person related to you by blood or marriage;
- a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- your attending physician;
- an employee of your attending physician;
- an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of a health care facility or of any parent organization of the health care facility; or
- a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.