HAHN LOESER

_____

Print Your Name

Letter of Instruction To My Health Care Representative

INTENT

In order to assist my Health Care Representative in making health care decisions for me as comfortably and confidently as possible, I leave these specific instructions to be incorporated by reference into the terms of my Health Care Power of Attorney.

DECISION MAKING

_____ I do not wish the appointment of my Health Care Representative to be perceived as an expression of distrust or a lesser level of confidence in other family members. In fact, I hereby direct my Health Care Representative to consult, to the fullest extent possible, with all members of my immediate family regarding my health care decisions, particularly those concerning:

_____ An emergency health care situation.

_____ The withholding or withdrawal of treatment should I be in a terminal or irreversible condition.

_____ I urge my Health Care Representative to consult with the following individuals regarding termination of artificial life support treatments.

___ Religious clergy: _____

___ Medical professional: _____

___ Trusted friend: _____

___ Other: _____

_____ I have the following specific instructions for my Health Care Representative concerning the making of medical decisions on my behalf:_____

_____

_____

MEDICAL RECORDS

_____ I specifically authorize and direct my attending physicians, hospitals, or other health care providers to give my Health Care Representative the same access and same assistance in understanding my medical records as they would have given me.

_____ I authorize and encourage my Health Care Representative to take my medical records to another physician to get a second opinion before making a medical decision for me.

_____ I encourage my Health Care Representative to share the information in my medical records with the members of my immediate family.

_____ I am concerned about privacy. I direct my Health Care Representative not to show my medical records to other family members or third parties.

_____ I have the following specific instructions regarding the access and/or use of my medical records:_____

_____

_____

CHOICE OF DOCTORS

_____ I have placed complete trust in my Health Care Representative in both the hiring and termination of a physician. I ask my Health Care Representative to exercise the same diligence in this matter, as he or she would do for his or her own children, spouse, or other family members.

_____ I prefer my medical treatment continue with my primary care physician for as long as possible. I direct my Health Care Representative to maintain this relationship:

_____ Despite any future changes in my existing insurance coverage which might adversely impact me financially to continue such relationship.

_____ Unless a future change in my existing insurance coverage would adversely impact me financially to continue such relationship.

_____ If my primary care physician is unable to continue my medical treatment for any reason, I request my Health Care Representative to:

_____ Consult with my primary care physician to obtain a referral to a quality physician in the same locality, if possible.

_____ Consult with the following individual(s) regarding the selection of a physician for my medical care:_____

_____

_____ Select a physician affiliated with the following hospital or treatment facility:

_____

_____

_____ I request that my Health Care Representative seek treatment for me, whenever economically feasible, with a specialist in the area of my medical condition.

_____ I have the following specific instructions regarding the selection of physicians for my medical care: _____

_____

_____

HEALTH CARE FACILITY PREFERENCE

(Note: Some individuals may wish to rank their facility preferences by listing a number on the line to the right of the types of care facilities centered below)

HOME CARE ____

_____ My preference is to remain in my home as long as economically and medically possible, and I direct my Health Care Representative to consult the Trustee of my Living Trust regarding the use of my trust assets to provide any necessary home remodeling, hiring of assisted living professionals and/or visiting medical professional.

_____ I direct my Health Care Representative and the Trustee of my Living Trust to take whatever measures necessary to allow for my in home health care needs, even if such directive should result in the depletion of all of my assets.

_____ Although my choice is to remain in my home, my overriding concern is to not burden my loved ones. As such, I direct my Health Care Representative to carefully consider the impact upon my loved ones when determining whether or not in home health care is in my best interest.

_____ I encourage my Health Care Representative 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 which provides home-assistance services, including: _____

_____

_____ During any time when I need in home assistance, I request my Health Care Representative to determine if the following individual is able and willing to reside with me and provide the services necessary for me to remain in my home:

(feel free to check off as options or rank them in order of preference)

_____ Any family member.

_____ The following family member:_____

_____ The following friend:_____

_____ During any period of time when such family member / friend may reside with me to provide the necessary services for me to remain in my home, I direct my Health Care Representative to:

_____ Not charge this family member / friend room or board fees.

_____ Submit a reasonable compensation request to the Trustee of my Living Trust as a health care expense, upon the written request of this family member / friend.

_____ Visit my home, at least weekly / monthly / quarterly, to determine that the level of care I am receiving is appropriate.

ALTERNATIVE HOME CARE ____

_____ Should my Health Care Representative determine that continuing my health care in my home is no longer in my best interest (after considering the directives set forth above), I direct my Health Care Representative to consult with the Trustee of my Living Trust regarding the selling of my then current home and purchasing a more suitable residence in which my health care may still be administered in an "in home," independent environment. When selecting a new home for me, I direct my Health Care Representative consider the following: *(feel free to check off as options or rank them in order of preference)*

_____ Proximity to family (specifically:_____)

_____ Proximity to friends (specifically:_____)

_____ Specific neighborhood / community:_____

_____ Other:_____

_____

_____

FAMILY MEMBER'S HOME CARE ____

_____ 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 Representative to determine if a family member is able and willing to take care of me in his or her home.

_____ During any time when a family member provides home assistance services to me and I am residing in that family member's home, I direct my Health Care Representative to:

_____ Submit a reasonable compensation request to the Trustee of my Living Trust as a health care expense, upon the written request of this family member.

_____ Visit the home at least weekly / monthly / quarterly to determine that the level of care I am receiving is appropriate.

_____ Despite the willingness of one of family members to have me live with him or her in their home, I do not want to be a burden to my loved ones, and I direct my Health Care Representative to kindly refuse on my behalf and to make alternative care arrangements.

NURSING HOME/INSTITUTIONAL CARE ____

_____ When I can no longer maintain my independent lifestyle, with occasional care from family members or home-assistance agencies, I wish to move to a nursing care facility which can provide me with the appropriate level of care while maintaining the greatest degree of independence that my condition may allow.

_____ During any time when my Health Care Representative believes that I can no longer receive appropriate care in my home or in a family member's home, I direct my Health Care Representative seek supporting certifications in writing from my primary care physician and an appropriate specialist recommended by my primary care physician and approved by my Health Care Representative. Upon receipt of these certifications, I authorize my Health Care Representative to select for me, and admit me into, a nursing care facility.

_____ When selecting a nursing care facility, I direct my Health Care Representative to consider: *(feel free to check off as options or rank them in order of preference)*

_____ The following facilities: _____

_____

_____

_____ A facility with the following qualities: _____

_____

_____

_____ A facility located in the community where I live

_____ A facility located near my family (specifically: _____
_____)

_____ A facility operated in accordance with my religious beliefs

_____ A facility located near the following hospital or treatment center: _____
_____

_____ When selecting a nursing care facility, I request that my Health Care Representative consult my family members to select a facility where my family members would feel comfortable visiting me.

_____ I qualify for admission to particular nursing care facilities because of my service as (veteran /clergy/other _____). I direct that my Health Care Representative consult the following benefit program when selecting a nursing care facility:
_____
_____

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

_____ My Health Care Representative shall inspect 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 Representative shall determine to be important to the selection of a quality nursing care facility.

_____ During any time when I live in a nursing care facility, I direct that my Health Care Representative visit me (weekly / monthly / other: _____
_____) to determine that the level of care I am receiving is appropriate.

_____ During any period of time that I might still be able to interact with facility residents and participate in activities, I direct that my Health Care Representative consider the following nursing care facility or other similar facility: _____
_____
_____

_____ During any period of time that I am unable to interact with facility residents and participate in activities, I direct that my Health Care Representative consider the following nursing care facility or other similar facility: _____
_____

MEDICATIONS

_____ I authorize my Health Care Representative 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.

_____ I desire that my Health Care Representative be very cautious when consenting to any addictive medications.

_____ I prefer the use of natural vitamin and nutrition treatment whenever potentially beneficial to my condition.

_____ I do not wish to participate in unconventional or experimental medication or therapy.

OR

_____ I authorize the use of unconventional or experimental medication or therapy, whenever possible.

_____ However, I am concerned about the high cost often associated with unconventional or experimental medication or therapy. I direct my Health Care Representative to balance the cost of the medication or therapy with the expected relief.

_____ I direct my Health Care Representative 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.

_____ I leave the following instructions regarding the use of medications: _____

_____

_____

_____

MEDICAL TESTS

_____ I direct my Health Care Representative to not allow any tests to be performed on me, 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.

_____ I encourage my Health Care Representative to get second opinions from appropriate specialists, if economically feasible, before authorizing or not authorizing any testing which my attending physician and/or primary care physician believe would be beneficial in restoring my health.

MEDICAL HISTORY

_____ I wish to inform my Health Care Representative of my tendency to have allergic or other adverse reactions to the following substances:_____

_____

_____ I wish to inform my Health Care Representative of the following family medical history:

_____

_____

_____

TERMINATION OF LIFE SUPPORT TREATMENT

_____ In conjunction with the directions in my Living Will and Health Care Power of Attorney, I direct my Health Care Representative to not allow any medical procedure that, in the opinion of my attending physician, is considered heroic or beyond those procedures usually performed for people in my condition.

_____ When my Health Care Representative has consulted with my attending physician, and any other physicians necessary, and the conclusion is that medical treatment is only artificially prolonging the dying process or that there is no reasonable chance of regaining consciousness, I direct my Health Care Representative to authorize my attending physician to enter a "no-code" or "do not resuscitate" order on my medical records. My Health Care Representative should never feel guilty about authorizing this course of action because this is the decision I would make if I were able to do so myself.

_____ I direct my Health Care Representative 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 treatments.

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

_____

QUALITY OF LIFE

_____ I consider the following activities/lifestyle opportunities to be essential for my quality of life, and I wish for my Health Care Representative and Trustee to make all reasonable action to assure I continue to have these basics (i.e. – access to outdoors, literature, spiritual support, music): _____

_____

_____

HOSPICE CARE

_____ I desire my Health Care Representative and Trustee to investigate and arrange for hospice care in the appropriate situation and direct them to consult with the following regarding such matters:

_____ My Primary Care Physician

_____ Other: _____

_____

_____

ORGAN DONATION

_____ I have left a directive regarding anatomical gifting in my estate-planning portfolio and direct my Health Care Representative to carry out this directive if at all possible under the circumstances.

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 person or persons named in my Health Care Power of Attorney.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of the month of _____, 20_____.

_____
SIGNATURE

Witnesses:

_____	_____
Signature	Signature
Printed Name: _____	Printed Name: _____
Address: _____	Address: _____
_____	_____

This document was prepared by:

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