

Moderate to Severe Dementia-Specific Health Care Directive Supplement:

Stopping / Not Starting Treatment Worksheet

Full Name: _____

Date of Birth: _____

I would want to stop and not start any life prolonging treatment: Mark answer with an X	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
If I could no longer live with my spouse / family member					
If I became physically and/or emotionally abusive					
If I was > 50% bedbound					
If I could no longer wipe myself					
If I had uncontrolled pain or other symptoms (agitation, nausea)					
If I had to be hand fed					
When I am a clear financial burden on my family					
If I was wheelchair bound and could not propel myself					
If I no longer recognized my spouse / family member					
If I was no longer able to do my hobby (_____)					
If I was no longer able to understand what I read or saw on TV					
If I had to wear a diaper					
If I were to require chronic dialysis (> 2 weeks)					
If I needed a feeding tube					
If I were to require a tracheostomy					
If the only option was to go to a nursing home or memory care					
If reached Stage 6 of Alzheimers' Disease					
If I scored ≤ 12 on the MOCA					
Other :					
Other :					
Other:					

Patient Signature: _____

Date: _____

Witness Signature 1: _____

Date: _____

Witness Signature 2: _____

Date: _____