
(YOUR NAME)

**LETTER OF INSTRUCTION
TO MY HEALTH CARE REPRESENTATIVE**

Dated: _____

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

SPECIFIC INSTRUCTIONS

The fact that I did not check a line does not indicate my disagreement with any instruction. Rather, I have indicated only those things, which, at the time, I feel strongly about. I have confidence my Health Care Representative will make the right decisions, and I want to give them as much discretion as possible to make these important decisions.

(Check boxes that are appropriate to indicate your wishes)

OUTSIDERS

{ } I have carefully selected the individuals I wish to make medical decisions for me in the event of my incapacity. It is my firm belief that these individuals are best positioned to make such decisions on my behalf. I wish to state emphatically that I do not wish to have other individuals or organizations involved in my health care decision-making.

{ } I urge my Health Care Representative to consult the following individuals regarding termination of artificial life support treatments:

___ Religious clergy:

___ Medical professional:

___ Trusted friend:

___ Other:

{ } I consider my health care a personal and private matter, and to the fullest extent possible under the law, I urge and request that there be no guardianship or other court intervention in my health care decision-making.

(Check boxes that are appropriate to indicate your wishes)

FAMILY MEMBERS

I have named Health Care Representative as my sole Health Care Representative. The intent of this action was to send one clear signal to my health care providers regarding my wishes, and to avoid even the appearance of conflict among my family and others concerned with my health care.

I do not wish the appointment of Health Care Representative as sole successor 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 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 the withholding or withdrawal of treatment should I be in a terminal or irreversible condition.

I direct my Health Care Representative to consult, to the fullest extent possible, with all members of my immediate family regarding any decisions made on my behalf during an emergency health care situation.

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 my Health Care Representative to consult with the following persons regarding any decisions made on my behalf during an emergency health care situation:

MEDICAL RECORDS

I encourage my Health Care Representative to obtain and use my medical records during any time when my Health Care Representative is making medical decisions for me.

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

I specifically authorize and direct my attending physicians, hospitals, or other health care providers to give my Health Care Representative the 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.

(Check boxes that are appropriate to indicate your wishes)

I encourage my Health Care Representative to share the information in my medical records with all 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.

CHOICE OF DOCTORS

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.

If my primary care physician is unable to continue my medical treatment for any reason, I request my Health Care Representative consult with my primary care physician to obtain a referral for a quality physician in the same locality, if possible.

If my primary care physician is unable to continue my medical treatment for any reason, I would like my new physician to be

- A male
- A female
- No preference

If my primary care physician is unable to continue my medical treatment for any reason and cannot refer another quality physician, I direct my Health Care Representative to obtain quality medical care for me. If my Health Care Representative is in doubt about whom to select for my medical care provider, 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 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.

HEALTH CARE FACILITY PREFERENCE

(Home care)

My preference is to maintain my current independent lifestyle for as long as possible.

When I can no longer lead an independent lifestyle, my first choice is to remain in my home. However, I realize there may come a time when my desire to remain in my home may burden my loved one's lives.

(Check boxes that are appropriate to indicate your wishes)

{ } 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.

{ } During any time when I need home-assistance, my Health Care Representative will assist any family member who comes forward and offers personal care to me in my home and shall determine if said member of my family is able to reside with me and provide a substantial part of the services necessary for me to remain in my home. If my Health Care Representative determines that said family member is able to provide a substantial part of the necessary services in my home, my Health Care Representative shall arrange additional services as necessary for my care in my home. My Health Care Representative shall also arrange alternative care in my home for no fewer than five days each month, and an additional period of no fewer than two weeks per year to provide said family member respite from providing my care. Said family member shall discontinue providing my care, without guilt or remorse, at any time after notifying my Health Care Representative that said family member will discontinue care.

{ } When a family member resides with me and provides the services necessary for me to remain in my home, I direct that no room or board fees be charged to this family member. Said family member shall not be responsible for maintenance or upkeep of my home.

{ } When a family member resides with me and provides the services necessary for me to remain in my home, I direct, upon request in writing to my Health Care Representative by this family member, that my Health Care Representative submit a reasonable compensation request to the Trustee of my TRUST as a health care expense.

{ } During any time when a family member resides with me and provides the services necessary for me to remain in my home, I direct my Health Care Representative to visit my home unannounced, at least bi-weekly, to determine that the level of care I am receiving is appropriate. I further direct my Health Care Representative to arrange for a Visiting Nurse to visit my home unannounced weekly and report my condition and adequacy of care to my Health Care Representative and to the family member providing care.

(Family Member's Home Care)

{ } If my home cannot be used for any reason for home-assistance services provided by an outside agency and/or a family member, and if a family member on his or her own initiative, requests to provide a substantial portion of the care I require in his or her home, then I direct my Health Care Representative to determine if said a family member is able to provide a substantial portion of the care I require in his or her home. If my Health Care Representative determines that said family member is able to provide a substantial portion of the necessary services in his or her home, my Health Care Representative shall arrange additional services as necessary for my care in said family member's home. My health Care Representative shall also arrange alternative care in

(Check boxes that are appropriate to indicate your wishes)

said family member's home no fewer than five days each month and an additional period of no fewer than two weeks per year to provide said family member respite from providing my care. Said family member shall discontinue providing my care, without guilt or remorse, at any time after notifying my Health Care Representative that said family member will discontinue care.

{ } When a family member provides home-assistance services to me and I reside with that family member in his or her home, I direct, upon request in writing to my Health Care Representative by this family member, that my Health Care Representative submit a reasonable compensation request to the Trustee of my TRUST as a health care expense.

{ } During any time when a family member provides home-assistance services to me and I reside with that family member in his or her home, I direct my Health Care Representative to visit the home unannounced at least bi-weekly to determine that the level of care I am receiving is appropriate. I further direct my Health Care Representative to arrange for a Visiting Nurse to visit my family member's home unannounced weekly and to report my condition and adequacy of care to my Health Care Representative and to the family member providing care.

(Long-term/Institutional Care)

{ } I do not wish to burden my family members with my health care needs. 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 long-term care facility, which can provide me with the appropriate level of care.

{ } 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 long-term care facility.

(Choosing a Long-term Care Facility)

{ } If I must reside at a long-term care facility, to the extent it is economically feasible and medically advantageous, I direct my Health Care Representative to select the following facility:

(Check boxes that are appropriate to indicate your wishes)

If the above facility is not available or advisable in my Health Care Representative's sole discretion, my Health Care Representative should select a similar institution with the following qualities: _____

When selecting a long-term care facility, I direct my Health Care Representative consider facilities which can provide me with the appropriate level of care while maintaining the greatest degree of independence that my condition may allow.

When selecting a long-term care facility, I direct my Health Care Representative to first consider facilities located in the community where I live.

When selecting a long-term care facility, I direct my Health Care Representative to first consider facilities located in the community where a majority of my family lives.

When selecting a long-term 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 would prefer, if possible, a long-term care facility which is operated in accordance with my religious beliefs.

I qualify for admission to particular long-term 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 long-term 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 or direct to be inspected 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 important to the selection of a quality long-term care facility.

(Check boxes that are appropriate to indicate your wishes)

During any time when I live in a nursing care facility, I direct that my Health Care Representative visit me or direct visits to me

At least every week

At least every month

Other:

in order to monitor 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 long-term 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 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.

(Check boxes that are appropriate to indicate your wishes)

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.

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.

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.

(Check boxes that are appropriate to indicate your wishes)

{ } 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 urge my Health Care Representative to consult the following individuals regarding termination of artificial life support treatments:

- { } Religious clergy: _____
- { } Trusted friend: _____
- { } Other: _____

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

ORGAN DONATION

{ } If any tissues are sound and would be of value as transplants to help other people, I freely give my permission for the donation of my bodily organs as may be of help.

Dated on _____

Signature

Received from client
Typed

This document was prepared with the assistance of Benson & Case, LLP, 1660 S Albion Street, #1100, Denver CO 80222. (303) 757-8300