

# Values Worksheet

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The following are questions to think about as you make decisions and prepare documents for your health care wishes. You may want to write down your answers and give copies to your family and health care providers, or just use the questions for thought and discussion.

**How important to you are the following items?**

VERY IMPORTANT → NOT IMPORTANT

	4	3	2	1	0
<b>Letting nature take its course</b>	<input type="checkbox"/>				
<b>Preserving my quality of life</b>	<input type="checkbox"/>				
<b>Staying true to my spiritual beliefs and traditions</b>	<input type="checkbox"/>				
<b>Living as long as possible, regardless of quality of life</b>	<input type="checkbox"/>				
<b>Being independent</b>	<input type="checkbox"/>				
<b>Being comfortable and as pain-free as possible</b>	<input type="checkbox"/>				
<b>Leaving good memories for family and friends</b>	<input type="checkbox"/>				
<b>Making a contribution to medical research or teaching</b>	<input type="checkbox"/>				
<b>Being able to relate to family and friends</b>	<input type="checkbox"/>				
<b>Being free of physical limitations</b>	<input type="checkbox"/>				
<b>Being mentally alert and competent</b>	<input type="checkbox"/>				
<b>Being able to leave money to family, friends, charity</b>	<input type="checkbox"/>				
<b>Dying in a short time rather than lingering</b>	<input type="checkbox"/>				
<b>Avoiding expensive care</b>	<input type="checkbox"/>				

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## Please fill in the blanks below

1. What will be important to you when you are dying (e.g. physical comfort, no pain, family members present, etc.)?

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2. How do you feel about using life-sustaining measures in the face of terminal illness? Permanent coma? Irreversible chronic illness or disability (e.g. Alzheimer's disease)?

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3. Do you always want to know the truth about your condition?

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4. Do you have strong feelings about certain medical treatments? Some treatments you might want to decide about include: mechanical breathing (respirator), cardio-pulmonary resuscitation (CPR), artificial nutrition and hydration (nutrition and fluid given through a tube in the veins, nose, or stomach), antibiotics, kidney dialysis, hospital intensive care, pain-relief drugs, chemo or radiation therapy, and surgery.

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5. Would your feelings about these treatments change depending on your health condition and prognosis? Would you want to avoid certain treatments only when death was certain, or also when you would probably be left incapacitated? Would you want to avoid certain treatments if they were used only to prolong the dying process, but accept them if they would alleviate pain?

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6. What limitations to your physical and mental health would affect the health care decisions you would make?

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7. Do you want to have finances taken into account when treatment decisions are made?

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8. Do you want to be placed in a nursing home?

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9. Do you want hospice care, with the goal of keeping you comfortable in your home during the end of life, instead of hospitalization?

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10. Do you want to take part in making decisions about your health care and treatment?

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11. Do you want to be an organ donor at the time of your death?

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