

Dementia-Specific Living Will

Full Legal Name:

Date of Birth:

Address:

Introduction & Purpose

Quality of Life Preferences

Medical Treatment Preferences

If I am in an advanced stage of dementia, I do/do not want the following treatments:

Pain Management:

Artificial Nutrition and Hydration (Feeding Tubes):

Resuscitation:

Hospitalization or Transfers:

Personal & Spiritual Preferences

Other Directions or Requests

Health Care Proxy / Decision-Maker

Name:

Contact Information:

Relationship to Me:

Signatures

Signature
Date

Witness Signature
Date