

Putting Things in Order

My Last Wishes



Essential Medical Information

Essential Financial Information

Where My Things are Located

Instructions for an Emergency

My Final Instructions

Demonstration Copy

Prepared by

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Demonstration Copy

How to Use this Program

Here are some things you should know about using this system:

1. Note that this system is a PDF. It can be read, viewed and filled in using the free Adobe Reader. We recommend that if you don't already have it you download the latest version of the Reader from the Adobe website. Go to:
<http://get.adobe.com/reader/>
2. You can fill in the information on-screen or in handwriting first. In fact, we suggest you print a section before you fill it out on screen and fill it out or make notes in handwriting. Then fill it out on the screen. You can change and print out the pages as many times as you wish.
3. There are two ways to use this program after you have filled in the information.
 - a. At any time you can print out a section just by pressing the **Print This Section** button located at the top of each section. You can do this before entering any information so you have blank lines to fill in by hand **OR** you can do this after you've filled in the section. You can do this as many times as you want. So you can make multiple hard copies of particular sections you may want to give to others. Note that the **PRINT** button is visible on-screen but doesn't appear when you print out a section.

b. You can keep the computer file on your computer with the information filled in. Or, you can copy the file and send it to a friend or relative who can view it on their computer (and add to the information.) Be sure to always keep a copy of the file as a backup.

4. You don't have to worry about making a mistake when filling in the blanks on the screen. Just backspace or use the delete key to correct any mistakes. Also note that when you reach the end of a line you can continue typing, but the size of the type will shrink; so use the **TAB** key or your mouse to go to the next line.
5. Remember, **how you organize** or complete each section is up to you. So you can complete any section in any order, or choose not to complete a section if you wish. When you are done, you can assemble the printed sections in any order you wish. Note that there is a wide margin on the left side of the page to accommodate a three ring binder or spiral binder
6. Note that extra pages are available from the menu for multiple marriages, divorces or just to supplement particular sections. When printed they can be inserted wherever appropriate. Also remember that **you do not have to complete all sections** - only do the ones that you care about or are appropriate.
7. Notice that there are pages (**Comments-Others**) that may be completed by others. This is an opportunity to let friends or relatives add to your story and provide more insight about your life. You can print out that section and send it to them and ask

them to complete it and send it back for you to add to this document.

Finally, we would very much like your input about this system, how it could be improved and suggestions for other publications.

We hope you are aware that the Virginia M. Woolf Foundation provides books in large print - 18 and 28 point type - in a pdf file, for those people who need larger than normal print to read comfortably or in ASCII for screen readers for the blind.

You can send us an email at **Woolf-Foundation@ca.rr.com** or go to our website at **www.extralargeprint.org**

You can also ask for help by telephone: (424) 263-2057

Who I Am - Medically

My full name is _____ . I live at _____
_____ I was born on _____

I am completing this section on (date) _____

I live with _____ I LIVE ALONE

My blood type _____ Height _____ Weight _____

Eye color _____ Hair color _____

I Do Don't Wear eyeglasses
For reading Every day

I Do Don't Wear a hearing aid

I Do Don't Wear dentures

I Do Don't Have a pace maker or other implant

Normally my blood pressure is ____/____ pulse is ____

I am Right-handed Left-handed Ambidextrous

I have devices _____

I take the following medications daily _____

I have drug or allergy sensitivities _____

My Doctor's name or health plan is _____

His phone number or address is _____

My Dentist's name or health plan is _____

His phone number or address is _____

My plan or record number is _____

I was last hospitalized on _____ For _____

Before then, I was hospitalized on _____ For _____

(More hospitalizations are listed on page 4)

My last tetanus shot was on _____

In the event of an emergency call _____
At _____

A second person to call in an emergency is _____
At _____

In the event of my serious illness or death, I wish the following
people to be notified _____

I HAVE BEEN TOLD I MAY HAVE:

WHEN

Lung disorder	Yes	No	_____
High blood pressure	Yes	No	_____
Heart trouble	Yes	No	_____
Nervous disorder	Yes	No	_____
Disease of digestive tract	Yes	No	_____
Any form of cancer	Yes	No	_____
Disease of the kidney	Yes	No	_____
Diabetes	Yes	No	_____
Arthritis	Yes	No	_____
Hepatitis	Yes	No	_____
Malaria	Yes	No	_____
Blood disease	Yes	No	_____
HIV	Yes	No	_____
Asthma	Yes	No	_____
Tuberculosis	Yes	No	_____
High Cholesterol/take meds	Yes	No	_____
Anemia	Yes	No	_____
Bleeding Disorder	Yes	No	_____
Cancer	Yes	No	_____

Liver Disease Yes No _____

Epilepsy Yes No _____

Alcohol/Drug abuse Yes No _____

Immune problems Yes No _____

Physical defect (describe) Yes No _____

Vision or hearing disorders (describe) _____

Any contagious disorders (describe) _____

If I am not able to do it myself, please _____

I have given a medical power of attorney to _____

They have the authority to determine the treatment I receive or to authorize withholding treatment.

My lawyer's name is _____

His address is _____

My will is located _____

I have important papers at _____

More about my medical condition _____

I was hospitalized on _____ For _____

I was hospitalized on _____ For _____

I was hospitalized on _____ For _____

I was hospitalized on _____ For _____

My health has has not changed in the last _____

I am concerned that _____

FAMILY HEALTH

On my **Mother's** side of the family these relatives had these diseases or conditions:

Breast Cancer: _____

Prostate Cancer: _____

Cancer of the _____: _____

Heart Attack before 60: _____

Heart Attack after 60: _____

Stroke: _____

Type 1 Diabetes: _____

Type 2 Diabetes: _____

Arthritis: _____

On my **Father's** side of the family these relatives had these diseases or conditions:

Breast Cancer: _____

Prostate Cancer: _____

Cancer of the _____: _____

Heart Attack before 60: _____

Heart Attack after 60: _____

Stroke: _____

Type 1 Diabetes: _____

Type 2 Diabetes: _____

Arthritis: _____

My **siblings** have _____

My Financial Information

I have a safe deposit box at

_____ Bank
_____ Bank Addr.

I have a safe deposit box at

_____ Bank
_____ Bank Addr.

Checking and Savings Accounts

_____ Bank
_____ Bank Addr

Checking and Savings Accounts

_____ Bank
_____ Bank Addr

Checking and Savings Accounts

_____ Bank
_____ Bank Addr

I have a stock brokerage account at

Address _____

I have a mutual fund with

I have life insurance with _____

Policy # _____

I have health insurance with _____

Policy # _____

I have auto insurance with _____

Policy # _____

I have home owner's insurance with _____

Policy # _____

I executed a **Power of Attorney** on ____/____/____ which authorizes _____ to sign checks, open the safe deposit box and manage all my accounts.

I did not execute any Power of Attorney.

My Will is located

I named _____ as executor.

A copy of my will is located

Documents are Located:

Included

Computer file

Physical location

Adoption papers

Baptism certificates

Bills, statements

Birth certificates

Business records

Citizenship records

Contracts

Court records

Date books

Death certificates

Demonstration Copy

- Deeds _____
- Diaries _____
- Diplomas _____
- Discharge papers _____
- Divorce decrees _____
- Donation receipts _____
- Drivers licenses _____
- Employment records _____
- Genealogies _____
- Graduation books _____
- Immunization records _____
- Income tax returns _____
- Insurance papers _____
- Investment records _____

Demonstration Copy

Leases

Ledger books

Loan agreements

Marriage certificates

Medical records

Passports

Pay statements

Pension statements

Petitions

Photographs

Powers of attorney

Receipts

Resumes

School awards

Demonstration Copy

School transcripts _____

Social security cards _____

Sports awards _____

Test reports _____

Vehicle registrations _____

Voter registration cards _____

W-2s _____

Wills _____

Demonstration Copy

Emergencies and End of Life

I want to be prepared for medical emergencies by giving my heirs and friends information and directions when I am no longer able to decide for myself. Therefore, this document is being prepared on _____ . This is not a will, but it supercedes any document prepared before that date except my will or medical power of attorney.

My doctor(s) is _____ at _____
My doctor(s) is _____ at _____
My doctor(s) is _____ at _____
My doctor(s) is _____ at _____
My lawyer(s) is _____ at _____

The person who has a medical power of attorney is _____
who's address and phone number is _____

Another person who has a medical power of attorney is _____
who's address and phone number is _____

My will and/or living trust document is located _____

The executor of my will is _____ who resides at _____

An alternate executor of my will is _____ who resides at _____

I have health insurance policies with:

_____ act# _____
_____ act# _____
_____ act# _____

The policies are located _____

I have life insurance policies with:

_____ act# _____
_____ act# _____
_____ act# _____

The policies are located _____

I have extended care insurance policies with:

_____ act# _____
_____ act# _____

The policies are located _____

I have liability insurance policies with:

_____ act# _____
_____ act# _____
_____ act# _____

The policies are located _____

My Social Security information is located _____

I have prepared an Advance Directive for medical care dated and signed on _____. I desire that it be taken into account and followed. If it cannot be located or if there is any ambiguity I desire the following to take place in the event I cannot make the

decision(s) about my care myself:

In the event my doctors determine I have a life threatening condition I desire that my treatment be _____

In the event there is a choice between death and an attempt at revival, I desire that _____

and that this wish be communicated to my care-givers.

With respect to end of life care I prefer care _____ at home,
in a nursing home or _____ a dedicated hospice.

Before I die, I would like to see _____

I have made the following arrangements for my funeral and burial:

I desire _____ burial _____ cremation

I desire a _____ religious _____ military _____ commemorative
ceremony for my death _____ no celebration

If there is any question about these arrangement then I give the power of decision to _____

The following people should be notified immediately of my life-threatening condition or death:

_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____

These people should be notified as soon as possible:

_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____
_____ at _____

Demonstration Copy

_____ at _____

_____ at _____

I place _____ great _____ little importance on the circumstances of my burial or commemoration.

I will _____ fight _____ accept death because _____

I want you to know _____

Preparing for the Voyage - Final Instructions

I know that sometime in the future I will die. Whether it's tomorrow or years from now I want to do what I can to exit in my own way. These are thoughts and suggestions for those who survive me.

I am writing this on _____ when my health is _____

I'd like to be remembered _____

I am particularly grateful that during my life I could _____

Now, I look back at the good times I've had. Particularly, _____

As far as regrets or unfinished business _____

I have prepared _____ a living will, _____ a medical power of attorney, _____ a will. These are located in _____

A copy of these documents can be found _____

The executor of my will is _____.

When I am sick and no longer able to express my wishes about my medical treatment, I wish

That all possible means be used to prolong my life

That no extraordinary means be used to prolong my life

That the decisions about my medical treatment be made by ____

If possible I prefer that my last days be spent _____ at home,
in a medical facility. _____

In addition to my family, before I die I'd like to see _____

I'd also like to _____

I'd also like help with _____

When I die I prefer that there be _____ no commemoration
no funeral and that I be quickly _____ cremated _____ buried.

I would like to have a commemoration ceremony at which
people could express their feelings about my life.

I would like to be buried in a ceremony presided over by _____

and buried in _____

If appropriate I would like _____ (music)
at the ceremony.

I have already made arrangements with and paid for the cost of my funeral and grave site with _____

In any obituary notice I want the request made that in lieu of flowers people may make a donation to _____
_____ in my memory.

Final decisions about my funeral should be made by _____,
_____, but

I would like _____

My last thoughts or words of wisdom: _____

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Helpful Resources

Administration on Aging
Washington, DC 20201
202-619-0724
www.aoa.gov

Provides information for older Americans and their families on opportunities and services to enrich their lives and support independence.

Aging Network Services
4400 East-west Highway, Ste. 907
Bethesda, MD 20814
301-657-4329
www.agingnets.com

Nationwide network of private-practice geriatric social workers serving as care managers for seniors living at a distance from their families.

Alzheimer's Association
225 N. Michigan Ave., Floor 17
Chicago, IL 60601
800-272-3900
www.alz.org

National organization that provides information on Alzheimer's services, programs, publications and local chapters.

Alzheimer's Disease Education & Referral Center
P.O. Box 8250
Silver Springs, MD 20907
800-4384380
www.Alzheimers.org

National Institute on Aging service that distributes information and free materials on topics relevant to health professionals, patients and their families.

Alzheimer's Foundation of America
322 Eighth Avenue, 6th Floor
New York, NY 10001
866-232-8484
www.alzfdn.org

National nonprofit foundation supporting organizations that help lighten the burden and improve the quality of life of Alzheimer's patients and their caregivers.

American Diabetes Association
1701 North Beauregard Street
Alexandria, VA 22311
800-877-1600
www.diabetes.org

America's leading nonprofit health organization providing diabetes research, information and advocacy.

American Dietetic Association
120 South Riverside Plaza, Ste. 2000
Chicago, IL 60606
www.eatright.org

Consumer nutrition hotline that provides information on finding a dietician.

American Geriatrics Society
40 Fulton Street
New York, NY 10038
www.americangeriatrics.org

Professional organization providing assistance in identifying local geriatric physician referrals.

American Heart Association
7272 Greenville Avenue
Dallas, TX 75237
800-242-8721
www.americanheart.org

Nonprofit health organization whose mission is to reduce disability and death from cardiovascular diseases and stroke.

American Society on Aging
833 Market Street, Ste. 511
San Francisco, CA 94104
800- 527-9728
www.asaging.org

National Organization concerned with physical, emotional, social, economic, and spiritual aspects of aging.

Family Caregiver Alliance
180 Montgomery Street, Ste. 1100
San Francisco, CA 94104
800-445-8106
www.caregiver.org

Resource center for families of adults with brain damage or dementia, which provides publications for caregivers and professionals.

The National Council on the Aging
300 D Street, SW Ste. 801
Washington, DC 20024
202-479-1200
www.ncoa.org

National network of organizations and individuals dedicated to improving the health and independence of older persons and increasing their continuing contributions to communities, society, and future generations.

National Osteoporosis Foundation
1150 17th Street, Ste. 850
Washington, DC 20036
800-231-4222
www.nof.org

Non profit organization dedicated to preventing and curing osteoporosis. Supports programs of awareness, education, advocacy and research.

National Stroke Association
9707 East Easter Lane
Englewood, CO 80112
800-787-6537
www.stroke.org

The mission is to reduce the incidence and impact of stroke disease and improve the quality of patient care outcomes.

Older Women's League
1627 Eye Street, NW Ste. 600
Washington, DC 20006
202-450-8986
www.owl-national.org

Advocacy organization addressing family and caregiver issues with focus on women over 40.

U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420
800-827-1000
www.va.gov

Provides information on VA programs , veterans benefits, and VA facilities worldwide

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