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Advance Healthcare Directive

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ADVANCE HEALTHCARE DIRECTIVE

Introduction

When a loved one suffers a life-threatening illness or accident, it puts great stress on the entire family. If that person is unconscious or otherwise incapacitated, someone will need to make medical decisions on their behalf. Unless the patient's wishes are recorded, and he or she has designated someone to represent them, it may be impossible for families to know and honor their loved one's wishes. That's why it's so important to have an Advance Healthcare Directive.

This serves as a legal record of your choices and instructions regarding your care in the event that you are unable to communicate or make your own decisions. It's a clear, legal means of recording your wishes regarding life support measures such as artificial respiration, nutrition, or hydration. By having an Advance Healthcare Directive, you or your loved one can feel confident that your wishes regarding end of life care will be understood and respected.

You have several options regarding how to use this form. You may:

- Name someone you trust as your proxy, or healthcare agent, to make healthcare decisions for you.
- Provide written instructions regarding your own future care.
- Name your healthcare agent AND provide written instructions.

Please note: If you choose not to provide written instructions, your healthcare agent will make decisions based on your spoken directions. If you are unable to communicate, your healthcare agent will have to base decisions on his or her understanding of your values and your wishes.

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Instructions

Part 1: What Quality of Life Means to Me — This section of this document is optional. It is designed to provide insight into what quality of life means for you.

Part 2: End of Life Preferences, also optional, is an opportunity to record your spiritual and other preferences regarding your last moments and funeral ceremony.

Part 3: Power of Attorney for Healthcare lets you name another individual as an agent to make healthcare decisions for you if you become incapacitated or determine that you want someone else to make those decisions for you. You have the right to designate any person of your choice, including an unmarried partner, as your medical decision-maker. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community or residential care facility where you are receiving care, or supervising healthcare provider or employee of the healthcare institution where you are receiving care, unless he or she is related to you or is a co-worker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

2. Select or discharge healthcare providers and institutions.

3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of healthcare, including cardiopulmonary resuscitation.

5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psycho-surgery, sterilization, or abortion for you.

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Part 4: Instructions for Healthcare is where you list your specific end-of-life preferences regarding end of life care and pain relief, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you wish to allow your agent to decide what is best for you, you don't have to fill out this part of the form.

Part 5: Donation of Organs at Death is where you can record your preferences regarding organ donation.

Part 6: Signature is the section you must sign and get notarized.

Part 7: Special Witness Requirement is only required if you are a patient in a skilled nursing facility and requires the signature of an ombudsman or patient advocate.

Part 8: Primary Physician is optional and allows you to designate a primary care physician if you so desire.

Part 9: Next Steps offers some helpful suggestions for next steps once your Advance Healthcare Directive is completed.

Give a copy of the signed and completed form to your physician, any other healthcare providers you may have, any healthcare institutions at which you are receiving care, and any healthcare agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take on the responsibility.

You have the right to revoke this Advance Healthcare Directive or replace this form at anytime.

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PART 1: What Quality of Life Means to Me (optional)

It's important to me for my agent, family, and friends to understand what good quality of life means to me. I am sharing some of the things I enjoy in life so you can have a clear understanding of what circumstances would make life, for me, no longer worth living.

To me, a perfect day would include:

Additional pages in back if needed

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I wouldn't want to live if I was not able to:

Additional pages in back if needed

I wouldn't want to live if I had to:

Additional pages in back if needed

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PART 2: End of Life Preferences (optional)

Everyone deserves to die in dignity and comfort. I have thought about how I would like to die, and I am listing my preferences below.

Where I would prefer to die:

Additional pages in back if needed

In my last moments, I would like the following arrangements (prayers, music, rituals):

Additional pages in back if needed

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My religion/spiritual affiliation:

I am of the _____ faith. If I am seriously ill or dying, I would like my agent to notify the _____ (church/temple/mosque) in _____ (city/state), at _____ (phone).

I would like my funeral to include the following arrangements (prayers, music, rituals):

_____

_____

_____

_____

_____

_____

_____

_____

Additional pages in back if needed

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PART 3: Power of Attorney for Healthcare

An agent can be a spouse, family member, or trusted friend. It's entirely up to you. The important thing is to choose someone you trust to honor your wishes. It's essential that you take the time to explain your views and treatment goals to your agent, and make sure they understand and are comfortable with your wishes.

Designation of Agent

I designate the following individual as my agent to make healthcare decisions for me:

Name: _____

Address: _____

Home: _____ Cell: _____ Work: _____

Optional: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a healthcare decision for me, I designate the following as my alternate agents:

First Alternative Agent: _____

Address: _____

Home: _____ Cell: _____ Work: _____

Second Alternative Agent: _____

Address: _____

Home: _____ Cell: _____ Work: _____

Agent's Authority

My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare to keep me alive, except as I state here:

_____

_____

_____

Additional pages in back if needed

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When Agent's Authority Becomes Effective

My agent's authority becomes effective when my primary physician determines that I am unable to make my own healthcare decisions.

X _____
initial here

OR

My agent's authority to make healthcare decisions for me takes effect immediately.

X _____
initial here

Agent's Obligation

My agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare, any instructions I give in **PART 4** of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

Agent's Post-Death Authority

My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in **PART 5** of this form:

_____

_____

_____

_____

_____

_____

Additional pages in back if needed

Nomination of Conservator

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

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PART 4: Instructions for Healthcare

In the event that I lose my ability to communicate, or to make my own choices, I am asking my agent to make those choices for me, based on the specific preferences listed below. I also ask that my doctors and healthcare team honor these preferences. Should my agent, or alternate agents, be unavailable or unable to make decisions on my behalf, this document represents my wishes.

Note: If you fill out this part of the form, you may strike any wording you do not want.

End of Life Decisions

I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice not to prolong life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.

X _____
initial here

OR

Choice to prolong life

I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.

X _____
initial here

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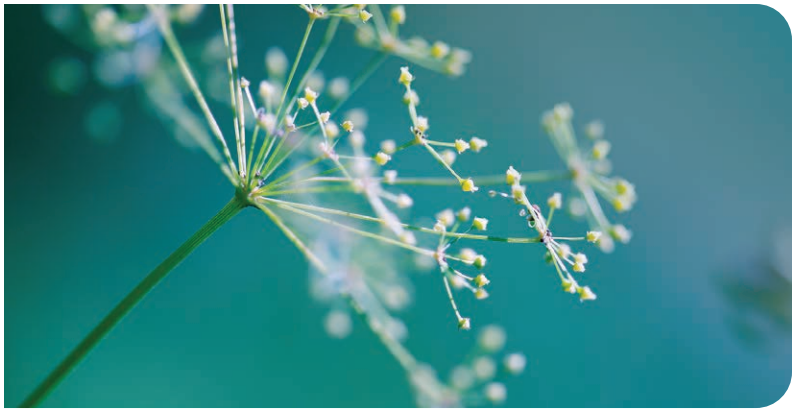

Relief From Pain

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort to be provided at all times, even if it hastens my death:

Additional pages in back if needed

Other Wishes

If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here. I direct that:

Additional pages in back if needed

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PART 5: Donation of Organs at Death (optional)

Upon My Death

Your agent may determine this for you if you have no strong preferences.

I give any needed organs, tissues, or parts.

X _____
initial here

OR

I give the following organs, tissues, or parts only:

X _____
initial here

_____

_____

_____

_____

_____

OR

I do not authorize the donation of organs, tissues, or parts.

X _____
initial here

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If you wish to donate organs, tissues, or parts, you must complete A and B.

A. My gift is for the following purposes.
Initial next to all that apply:

Transplant: X _____ initial here

Research: X _____ initial here

Therapy: X _____ initial here

Education: X _____ initial here

B. I understand that tissue banks work with both non-profit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside the United States.

1. My donated skin may be used for cosmetic surgery purposes. YES / NO X _____ initial here
2. My donated tissue may be used for applications outside of the United States. YES / NO X _____ initial here
3. My donated tissue may be used by for-profit tissue processors and distributors. YES / NO X _____ initial here

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PART 6: Signature

This form must be signed by you and by two qualified witnesses, or acknowledged before a notary public. Sign and date the form here:

Date: _____ Time: _____ am / pm

Signature: _____

Print Name: _____

Address: _____

Statement of Witness

I declare under penalty of perjury under the laws of California **(1)** that the individual who signed or acknowledged this Advance Healthcare Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, **(2)** that the individual signed or acknowledged this advance directive in my presence, **(3)** that the individual appears to be of sound mind and under no duress, fraud, or undue influence, **(4)** that I am not a person appointed as agent by this advance directive, and **(5)** that I am not the individual's healthcare provider, an employee of the individual's healthcare provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

Name: _____ Phone: _____

Address: _____

Date: _____ Time: _____ am / pm

Signature (witness): _____

Print Name (witness): _____

Second Witness

Name: _____ Phone: _____

Address: _____

Date: _____ Time: _____ am / pm

Signature (witness): _____

Print Name (witness): _____

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Additional Statement of Witness

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this Advance Healthcare Directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: _____ Time: _____ am / pm

Signature (witness): _____

Print Name (witness): _____

You May Use This Certificate of Acknowledgement Before a Notary Public Instead of the Statement of Witness

State of California, County of:_____

On (date) _____ before me, (name and title of the officer) _____

_____

_____

personally appeared (name(s) of signer(s), _____

_____ who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that foregoing p aragraph is true and correct.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature (notary): _____ **[SEAL]**

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PART 7: Special Witness Requirement

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

Statement of Patient Advocate or Ombudsman

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: _____ Time: _____ am / pm

Signature (patient advovate or ombudsman): _____

Print Name (patient advovate or ombudsman): _____

Address: _____

_____

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PART 8: Primary physician (optional)

I designate the following as my primary physician:

Name of Physician: _____

Address: _____

Phone: _____

Optional: If the above is not willing, able, to reasonably available to act as my primary physician, I designate the following as my primary physician:

Name of Physician: _____

Address: _____

Phone: _____

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PART 9: Next Steps

Your Advance Healthcare Directive is complete. Now what?

Talk to Your Loved Ones

If you haven't already done so, review your health are wishes with your agent and make sure he or she is willing and able to follow your wishes. Then, have a conversation with the rest of your family and any close friends who might need to know about your care decisions. Make sure they understand your wishes and know who you have selected as your agent.

Make and Distribute Copies of Your Directive

Give one copy of your Advance Healthcare Directive to your agent and another one to your doctor. Discuss your wishes with your doctor to make sure they are understood. Make a copy of the directive for yourself and put it someplace it can be easily found.

Have a Directive with You in these Instances

If you are going to a hospital or nursing home, or plan on being away from home for an extended period of time.

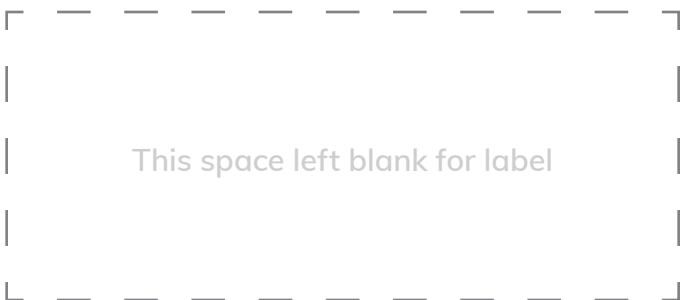
Review Your Directive Regularly

Over time, your beliefs, relationships, or general health may change. Something could happen to your agent, or your relationship with that person may evolve. In general, it's a good idea to revisit your directive under the following circumstances:

- The death of a loved one.
- A milestone birthday — entering a new decade of life.
- Divorce or other major family change.
- Being diagnosed with a serious health condition, or experiencing physical decline, especially if it jeopardizes your ability to live on your own.

Changing Your Advance Healthcare Directive

If your wishes change, simply fill out a new directive. Tell your agent, your doctor, your family, and anyone else who has a copy of your old directive, and make sure they have an updated copy.



Document Copies

The following parties have received copies of my Advance Healthcare Directive:

Primary Agent

Name: _____

Phone: _____ Email: _____

First Alternate Agent

Name: _____

Phone: _____ Email: _____

Second Alternate Agent

Name: _____

Phone: _____ Email: _____

Healthcare Provider/Hospital/Doctor's Office

Name: _____

Phone: _____ Email: _____

Other

Name: _____

Phone: _____ Email: _____

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Notes

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Notes

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