

# ADVANCE HEALTHCARE DIRECTIVE INFORMATION AND FORM

## INSTRUCTIONS

### ***What is an advance healthcare directive?***

An advance healthcare directive is a legal document in which you name a person to make healthcare decisions for you (an agent), usually when you are not able to make them for yourself. In the advance directive you also say what you want or don't want in your future healthcare. Through this document you can exercise your right to accept or refuse medical treatments, even if you lose your ability to make your own decisions.

- If you use this form, you may complete what you want of it or change what you want. You are free to use a different form.
- You don't need an attorney's services to complete the form.

### ***You have the right to change, suspend or revoke this advance healthcare directive at any time.***

In this form you say:

- a. whom you want to make healthcare decisions on your behalf (your agent);
- b. when you want your agent to make decisions for you
- c. what decisions you want the agent to make for you

Your agent may make all healthcare decisions for you, unless you choose to limit your agent's authority. If you choose not to limit the authority of your agent, your agent will have the right to make all medical healthcare treatment decisions regarding your physical health on your behalf. **NOTE:** An agent does not have the right to commit you to a mental health facility without your consent.

# ADVANCE HEALTHCARE DIRECTIVE FORM

FOR:

PROVIDED TO THE PUBLIC BY:



## PART 1- POWER OF ATTORNEY FOR HEALTHCARE: NAMING YOUR AGENT

Who cannot be your agent?

- a. An employee of a Nursing Home or residential care facility where you are receiving care
- b. Your doctor
- c. An employee of the hospital where you are receiving care, unless your agent is related to you or is a coworker

**DESIGNATION OF AGENT:** I designate the following individual as my agent to make healthcare decisions for me. My agent shall exercise this power and authority in accordance with my expressed desires and life-values, known to my agent, whether contained in this document or not. Before acting, my agent shall attempt to communicate with me regarding my desires unless such attempt would be futile. If my desires are unknown, then my agent shall decide for me, striving to represent my known preferences and life-values, keeping my best interests in mind and considering the quality as well as the physical extension of my life. I want my agent to carry out my known preferences and values, even if others in my family express disagreement.

Name of individual you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
(home phone) (work phone) (cell/pager)

OPTIONAL: If my agent is not available to make a healthcare decision for me, I designate as my alternate agent:

Name of individual you choose as alternate agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_  
(home phone) (work phone) (cell/pager)

**AGENT'S AUTHORITY:** In the event I become incapable of giving an informed consent to any healthcare decision, I hereby grant to my agent full power and authority to consent, refuse consent, or withdraw consent to any type of healthcare procedure, including any procedure to maintain, diagnose, or treat any physical or mental condition (except to commit me to a mental health facility without my express authorization), or to make any other healthcare decision, to the same extent that I could if I were competent to do so, subject to the terms of this document. My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial feeding and fluids and all other forms of healthcare to keep me alive, except as I state here:

\_\_\_\_\_  
\_\_\_\_\_

**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. \_\_\_\_\_ (Initial here)

OR

My agent's authority to make healthcare decisions for me takes effect immediately. \_\_\_\_\_ (Initial here)

## PART 2 - INSTRUCTIONS FOR HEALTH CARE

You can give specific instructions about any aspect of your healthcare, whether or not you appoint an agent. There are choices provided in this section to help you write down your wishes regarding providing, withholding, or withdrawal of life support treatments in case of critical illness or injury, as well as regarding the provision of pain relief.

### Treatment Choices (in the event of critical or terminal illness):

The following treatment choices explain some procedures which may be used to attempt to save or prolong your life. Options of treatment will be determined by your physician and will be influenced by the condition you are in when the choices have to be made.

#### **Examples of life-prolonging procedures include:**

**CPR (cardiopulmonary resuscitation) attempt:** An attempt by doctors and nurses to restore your heartbeat and breathing if both have stopped. Involves vigorous chest compressions, insertion of a breathing tube into your throat and your lungs, and the use of a breathing machine.

**Life support:** Machines and drugs that are used to do the job of your organs that have failed.

**Surgery, lab studies, blood transfusion, antibiotics.** These tests and treatments may help to save or preserve your life when you are critically ill. If your doctors say that you are too sick to recover, these same tests and treatments may interfere with the natural progression of death, and may prolong your suffering.

**Tube feeding:** If you are not able to swallow or digest food and drink, tubes may be used to feed or provide fluids to you, either through your stomach or into your vein.

**END-OF-LIFE DECISIONS:** I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw the following treatment in accordance with the choice I have marked below:

#### **Choice To Prolong Life:**

\_\_\_\_\_ I want my life to be prolonged as long as possible, using all medical means available, within the limits of generally **(initial here)** accepted healthcare standards.

**OR**

#### **Choice Not To Prolong Life:**

\_\_\_\_\_ I do not want my life to be prolonged by the treatments below if (1) I have an incurable and irreversible condition that will **(initial here)** result in my death in 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 burdens of treatment would outweigh the expected benefits. In other words, I want my agent to consider both the extension of my life and the kind of life that I am likely to have should medical treatments be successful.

#### **RELIEF FROM PAIN:**

\_\_\_\_\_ I direct that treatment for alleviation of pain or discomfort be provided at all times.  
**(initial here)**

#### **SPECIFIC TREATMENT CHOICES**

(Checking "YES" means I WANT the treatment. Checking "NO" means I DO NOT WANT the treatment.)

	<u>Yes</u>	<u>No</u>
CPR (heart/lung resuscitation when breathing & heartbeat stop)	_____	_____
Life Support (by machines and drugs)	_____	_____
Surgery, blood, antibiotics, lab studies, etc.	_____	_____
Tube feeding/fluids by vein or stomach tube	_____	_____

### **PART 3 - SIGNATURES**

The form must be signed by you and by two qualified witnesses, OR acknowledged before a notary public. If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must witness the form.

**SIGNATURE:** Sign and date the form here:

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(sign your name) (print your name)

Address: \_\_\_\_\_

STATEMENT OF WITNESSES: 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: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

### **SECOND WITNESS**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**ADDITIONAL STATEMENT OF WITNESSES:** 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.

Signature of Witness: \_\_\_\_\_

**YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.**

State of California        )  
  )  
  )  
County of \_\_\_\_\_

On **(date)** \_\_\_\_\_ before me, **(here insert 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 the foregoing paragraph is true and correct.**

**WITNESS my hand and official seal.**

Signature of Notary: \_\_\_\_\_ **(Seal)**

**PART 4--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: \_\_\_\_\_

Name: \_\_\_\_\_  
(sign your name)

\_\_\_\_\_  
(print your name)

Address: \_\_\_\_\_

# WHAT TO DO WITH THIS ADVANCE HEALTHCARE DIRECTIVE FORM NOW?

1. Keep your original. Put it with your personal files where it is accessible to others.
2. Complete a wallet-sized copy and carry it with you.
3. Give a copy to your doctor(s).
4. Take a copy with you to the hospital each time you are admitted.
5. Give a copy to your designated healthcare agent and alternate (if you named one). Discuss with him/her what your decisions are, your goals of care, and what you want him/her to consider when making decisions on your behalf.
6. Tell your closest relatives or friends what is in your advance healthcare directive.
7. Give a copy to your religious or spiritual advisor.
8. If you have an old, outdated advance healthcare directive, destroy the old document.
9. To protect against loss of copies, consider electronic registry of your advance healthcare directive, a one-time registration process: <http://www.uslivingwillregistry.com/register.shtm>
10. If you do not want CPR/resuscitative measures to be attempted outside the hospital, you should complete a separate California pre-hospital DNR form. Available at <http://www.emsa.ca.gov/aboutemsa/dnrform.doc>