

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. 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 care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (e) Make anatomical gifts; authorize an autopsy and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, 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. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Part 5 of this form is the section for signatures and witness statements.

Part 6 of this form contains special information if you are presently in a skilled nursing facility.

Part 7 contains an optional form that may be used to express your personal views about life support at the end of life. This optional form may be used by your doctors and your loved ones as a guide if they ever have to make health care decisions for you.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a Notary Public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care 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 the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone) (cell phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(name of individual you choose as first alternate agent)

(address) (city) (state) (zipcode)

(home phone) (work phone) (cell phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is not willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address) (city) (state) (zipcode)

(home phone) (work phone) (cell phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(add additional sheets if necessary)

(1.3) 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 health care decisions unless I mark the following box.

If I mark this box , my agent's authority to make health care decisions for me takes effect immediately.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 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 health care 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.

(1.5) AGENT'S POSTDEATH 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 3 of this form.

(add additional sheets if necessary)

(1.6) 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.

PART 2
INSTRUCTIONS FOR HEALTH CARE

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

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

(a) 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, OR

(b) Choice to prolong life

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

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

(add additional sheets if needed)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

(3.1) Upon my death (mark applicable box)

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs tissues or parts, only.

(c) My gift is for the following purposes (strike any of the following you do not want):

- (1) Transplant
- (2) Therapy
- (3) Research
- (4) Education

(d) I do NOT wish to donate any organs, tissues or parts.

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

(name of physician)

(address)

(city)

(state)

(zipcode)

(phone)

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

(name of physician)

(address)

(city)

(state)

(zipcode)

(phone)

PART 5
SIGNATURES/WITNESS STATEMENT

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

_____ (date)	_____ (sign your name)	
_____ (address)	_____ (print your name)	
_____ (city)	_____ (state)	_____ (zipcode)

(5.3) STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care 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 health care provider, an employee of the individual's health care 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 print name	_____ Second Witness print name
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Signature of Witness	_____ Signature of Witness
_____ Date	_____ Date

PART 6
SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility-a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. 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)	_____ (sign your name)	
_____ (address)	_____ (print your name)	
_____ (city)	_____ (state)	_____ (zipcode)

MEDICAL CARE PREFERENCES

(Optional – Additional Statement for Durable Power of Attorney for Health Care)

This document gives you a chance to put in writing your views about life support at the end of life, to help guide your doctors and loved ones if they ever have to make some decisions for you. It is important to make sure that your wishes are known if and when that time ever comes.

Please read the following questions and answer them as best you can. But first, let's define "life support". Life support means any machines or medications that are needed to keep you alive. This usually includes a ventilator, which involves a tube that goes down the throat that is connected to a machine that pushes air into the lungs. It can also include things like feeding tubes, kidney dialysis, and intravenous lines for medications. Once life support is started, it can always be stopped if it looks like it is not helping or not what you would have wanted. If you have any questions about what life support is or what kinds of things you may need to consider in particular, please ask your doctor.

If you had a serious illness (like pneumonia) that **temporarily** required life support to cure you, and your doctors thought they could get you better, would you want life support?

Yes No Unsure Leave it up to my doctors and loved ones

If you were most likely **not** going to recover and would die at some point on the machines (for example, permanent coma or lung failure, kept alive on machines but would never get off) would you want life support?

Yes No Unsure Leave it up to my doctors and loved ones

If you develop a condition like advanced Alzheimer's disease or a severe stroke and eventually become unable to talk with others or enjoy life, would you want life support treatments that would prolong your life (like antibiotics for pneumonia, or tube feedings for the inability to swallow)?

Yes No Unsure Leave it up to my doctors and loved ones

Please add here any other particular concerns or issues you have that you would like your doctors and loved ones to use in making decisions about your care at the end of life:

Signature _____ Date _____

IMPORTANT: Be sure to talk to your loved ones about your wishes. Knowing your wishes will make it easier for them if and when these types of decisions need to be made.