CALIFORNIA

Advance Health Care Directives

Prepared for: _____

On this _____ day of _____ in the year _____

Legal Documents

To Assure Future Health Care Choices

Advance Health Care Directives

California and federal law give you the right to give instructions about your own health care, and the option to name someone else to make health decisions for you. You have the right to make these desires known to your doctor, hospital, or other health care providers. You have the right to be told about the your health in terms that you can understand, including the general nature of treatments and risks of failing to undergo them and any alternative treatments or procedures that may be available to you.

There may be a time when you are unable to make your wishes known to your medical provider. For example, if you were taken to the hospital in a coma, you would want the medical staff to know your specific wishes about the care you want or do not want to receive.

Advance directives are legally valid documents which state your choices about medical treatment and give you the opportunity to name someone to make decisions about your medical treatment if you are unable to make these choices yourself. They are "advance" directives because they are assigned in advance to let your doctor and other health care providers know your wishes concerning medical treatment.

It is entirely up to you whether you want to prepare these documents or not, but if questions arise about your wishes in regards to medical treatment, advance directives may help address and solve these important issues. Your doctor cannot require an advance directive in order to provide care, nor prohibit you from having one. Moreover, under California law, no provider or insurer may change different fees or rates depending on whether or not you have an advance directive.

It's important to know that these advance directives only go into effect when you can no longer make your own health care decisions. Your doctor will rely on **YOU** and **NOT** your advance directives as long as you are able to provide "informed consent." Informed consent may be defined as, "the ability to understand the nature, extent and probably consequences of proposed medical treatments and the ability to make rational evaluations of the risks and benefits to those treatments compared with the risks and benefits of alternate procedures AND you are able to communicate that understanding in any way."

Before writing anything down, speak with the people closest to you who are concerned about your care and feelings. Your loved ones and other appropriate people, such as a member of your clergy or your lawyer, are the people who will be involved in your health if you are unable to make your own decisions.

Keep your advance directives in a safe place where your family can access them. Share copies of these documents with as many of the following people as you are comfortable with: your spouse and other family members, your doctor, your lawyer, your clergyperson, and any local hospital or nursing home where you may seek treatment or residence. Another idea is to keep a small card in your wallet or purse which states you have an advance directive and who to contact.

If you use this form for your Advance Directive,
you may complete or modify all or any part of it.

You are free to use a different form.

INSTRUCTIONS

Part 1 of this form 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.

Unless your agent is related to you or is a coworker, your agent may not be:

- An operator of a community care or residential facility where you are receiving care
- An employee of the health care institution where you are receiving care
- Your supervising health care provider

Unless 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 your physical or mental condition
2. Select or discharge health care 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 health care, 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, psychosurgery, sterilization or abortion for you.*

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. You also can add to the choices you have made or write down 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.

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.

Name of Patient: _____

Date of Birth: _____

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

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: _____

_____

Home Phone: _____

Cell phone: _____

OPTIONAL:

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

Name of individual you choose as alternate agent:

Name of individual you choose as agent:

_____

Address: _____

_____

Home Phone: _____

Cell phone: _____

This section is continued on the next page.

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 needed)

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.

_____
(Initial here)

OR

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

_____
(Initial here)

This section is continued on the next page.

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 decision 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 POSTDEATH AUTHORITY:

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 who 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.

END OF LIFE DECISIONS:
I direct that my health care provider 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:

_____
(Initial here)

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

Choice To Prolong Life:

_____
(Initial here)

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

This section is continued on the next page.

RELIEF FROM PAIN:

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

_____

_____

_____

_____

_____

_____

_____

(Add additional sheets if needed)

OTHER WISHES:

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

I direct that:

_____

_____

_____

_____

_____

_____

_____

(Add additional sheets if needed)

PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

I. Upon my death:

I authorize the donation of any needed organs, tissues, or parts.

_____
(Initial here)

OR

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

_____
(Initial here)

OR

I authorize the donation of the following organs, tissues, or parts

Only: _____

_____

_____
(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete Sections II and III.

My gift is for the following purposes:

Transplant _____ *(Initial here)*

Research _____ *(Initial here)*

Therapy _____ *(Initial here)*

Education _____ *(Initial here)*

This section is continued on the next page.

III. I understand that tissue banks work with both nonprofit 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 transplant outside of the United States.

1. My donated skin may be used to cosmetic surgery purposes.

Yes _____ No _____
(Initial here) *(Initial here)*

2. My donated tissue may be used for applications outside the United States.

Yes _____ No _____
(Initial here) *(Initial here)*

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes _____ No _____
(Initial here) *(Initial here)*

(Health and Safety Code Section 7158.3)

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician:_____

Telephone: _____

Address: _____

_____

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:_____

Telephone: _____

Address: _____

_____

PART 5 – SIGNATURE

This form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

OTHER PROVISIONS

I hereby revoke any prior Advance Health Care Directive. This Advance Health Care Directive is intended to be valid in any jurisdiction in which it is presented. Photocopies of this Advance Health Care Directive may be relied upon as though they were the original.

This Advance Health Care Directive shall become effective upon my disability or incapacity; unless I have checked the appropriate box in Part 1, in which case, my agent's authority becomes effective immediately.

Signature: _____
(Patient)

Print name: _____
(Patient)

Date: _____ Time: _____ AM / PM

Address: _____

_____

_____

Telephone: _____

This section is continued on the next page.

STATEMENT OF WITNESSES:

I declare that under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health 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 advanced 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 health care facility, the operator of a residential care facility for the elderly, not an employee of an operator of a residential facility for the elderly.

FIRST WITNESS

Name: _____

Address: _____

_____

_____

Date: _____ Time: _____AM / PM

Signature: _____
(Witness)

Print name: _____
(Witness)

SECOND WITNESS

Name: _____

Address: _____

_____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(Witness)

Print name: _____
(Witness)

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 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 WITNESSES.

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 the foregoing paragraph is true and correct.

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

Signature: _____
(notary) [Seal]

PART 6 – 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 that I am serving as a witness as required by Section 4675 of the Probate Code.

Name: _____

Address: _____

_____

_____

Date: _____ Time: _____AM / PM

Signature: _____
(Witness)

Print name: _____
(Witness)

(Optional sheets to be used if more space is required)

Patient Name: _____

Date of Birth: _____

Section being continued: _____

[redacted]

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

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_____