MY ADVANCE DIRECTIVES

3401 W Sunflower Ave., Ste 100
Santa Ana, CA 92704
(888) 674-7159

Advance Health Care Directive

Please Note:

~ This is a personal document. You may alter it in any way you wish to make it convey your own views and life values.

~ Take your time in reading through this Advance Health Care Directive and think about what *your* wishes are in regards to health care treatments.

~ Choose your agent carefully, someone who knows you very well, and understands your life's values. Choose someone who will stand up and honor your wishes and is capable of making difficult decisions.

~ Your agent's role only becomes active if you cannot speak for yourself or communicate your health care decisions, unless you state otherwise.

~ Talk to your agent, family, and physician about what you want for yourself regarding health care wishes. It is the "key" in good advance health care planning. It is extremely beneficial in instituting your wishes, when family members have heard from you what it is that *you* want.

~ You can change or revoke your advance directive at anytime, verbally or in writing.

~ Your agent cannot consent to the following:

- Commitment to or placement in a mental health treatment facility
- Convulsive treatment
- Psychosurgery
- Sterilization
- Abortion
- Mercy killing, assisted suicide, or euthanasia

~ Please fill out an advance health care directive, do not burden your family with the stress of trying to determine your health care wishes when there is a crisis and you are unable to communicate.

Advance Health Care Directive

Introductory Information is Included as Part of this Document.

Here are the benefits of making out an Advance Health Care Directive.

- Your family and physician will not have to guess what treatment you want if you cannot speak for yourself. It protects them from making very difficult decisions.
- It opens the door for conversations so that your family, friends and your physician to know what YOU want done. This will help your family understand your wishes.
- You can stop worrying knowing that your health care decisions have already been made BEFORE a crisis strikes.

Some things you need to know:

- **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 if you cannot make the decisions or communicate them.
- This form lets you write down your wishes regarding donation of organs.
- This form lets you designate who you want as your primary physician.
- This form can be used by anyone 18 or older, who is married, single, an adult child, a friend, or parent.
- **This form can be changed or revoked at anytime,** which includes a verbal statement to your health care provider, which must be documented in your medical record.
- **If there is any additional information you would like to convey, please include as an attachment to this document.**

Information on Power of Attorney (Agent)

Part 1 of this form permits you to name another individual as your Power of Attorney (**agent)** to make health care decisions for you if you are incapable of making those decisions for yourself. You may also choose to have someone else make those decisions for you, even though you are still capable. You may name an **alternate agent(s)** to act for you if your first choice is unavailable or unable to make decisions for you. Your agent may make all health care decisions for you, unless you choose to limit the authority of your agent.

- **Choosing the right person as your agent:**
  - Pick someone who knows you very well, cares about you, and can make difficult decisions. A spouse or family member may or may not be the best choice. You know who would be best, and who would be able to stand up for you and follow your wishes.
  - Whomever you choose, talk over your wishes with them, **your family members, and your physician**. If you have children, speak with all of them at the same time.

- **Your agent may not be**:
  - Your primary physician or other medical professional who has undertaken primary responsibility for your care.
  - An employee of the health care institution where you are receiving care, an operator or employee of a community or residential care facility where you are receiving care, unless your agent is an employee related to you by blood, marriage, adoption, or is your registered domestic partner, or is your co-worker at the same institution or facility.

- **If you choose not to limit the authority of your agent, your agent will have the right to:**
  - Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose or otherwise affect a physical or mental condition.
  - Choose or discharge health care providers and institutions.
  - Agree or disagree to diagnostic tests, surgical procedures and medication plans.
  - Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
  - After your death, have your organs/tissues donated, authorize an autopsy, and make decisions about what will be done with your body.
  - Access medical records before and after your death.

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If you change your mind about a Health Care Agent:

- Destroy all copies of your advance directive *Or*….
- Sign a statement that you revoke the designation of an agent Or…
- Write the word "REVOKED" in large letters across the name of each agent whose authority you wish to cancel and sign your name on that page.
- In addition, notify your agent, physician or family that you have canceled or changed your agent.

Signatures and Witnesses

- The form must be signed and dated by you and by two qualified witnesses or a notary. **A notary is not required if the form is signed by two witnesses.**
- If you are a patient in a skilled nursing facility, the ombudsman or patient advocate must witness the form.

If you have A Medical Emergency in California

If you have a medical emergency and ambulance personnel arrive, and you do not want cardiopulmonary resuscitation (CPR) when you are dying, you will need to have a **Do Not Resuscitate** form filled out and **signed by a doctor in your possession/home. An advance directive will not prevent them from performing CPR.**

Part 1 Power of Attorney for Health Care

(1) 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 have given in Part 2 of the form, and any other wishes made known to my agent by me. To the extent that 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. My agent shall consider my personal values, the amount of pain/discomfort, the financial cost, the effect on my family and caregivers and compare these burdens with the expected benefits to the extent known to my agent. My agent has a duty under this advance directive to consult with me prior to any decision-making to obtain my instructions and wishes. My agent *may not* authorize medical treatment under this Advance Health Care Directive if I have capacity to give informed consent but refuse to do so, or if I revoke this Advance Health Care Directive.

(2) AGENT'S AUTHORITY: Unless I limit the authority of my agent, my agent is authorized to make all health care decisions for me, which include the following: (*strike out anything you do not wish*):

- Decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.
- Choosing or changing a particular physician.
- Accessing medical records before and after my death in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996.
- Receiving or consenting to release my medical information, including information contained in any medical opinion regarding my incapacity to give informed consent, except as stated here: _____
  _____
  _____

- Making decisions relating to my personal care including where I will live, provision of meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment *(check one box):*

☐ I accept

☐ I do not accept

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(3) AGENT'S POST-DEATH AUTHORITY *(mark applicable box):*

- Directing disposition of my remains in the following manner:
  - ☐ I want to be buried
  - ☐ I want to be cremated.

  My body or remains should be put in the following location: _____

  _____

- Making anatomical gifts or authorizing an autopsy.
- Donation of Organs at Death *(optional):*
  Upon my death:

  ☐ I give any needed organs, tissues, or parts.

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

  _____

  ☐ I donate my body or parts for the following purposes: *(strike any you don't want)*

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

  ☐ I do not wish to donate organs, tissues, or parts.

(4) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE *(check one box):*

☐ My agent's authority to make health care decisions for me becomes effective immediately.

☐ My agent's authority to make health care decisions for me becomes effective when my primary physician determines and documents in writing that I am unable (lack capacity) to make my own health care decisions.

(5) DESIGNATION OF AGENT FOR POWER OF ATTORNEY

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) (Relationship)

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

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

First Alternate Agent *(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 the following individual as my first alternate agent:

_____
(Name of Individual chosen as Alternate Agent) (Relationship)

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

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

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Second Alternate Agent *(optional)*: If I revoke my first agent's authority or if my first alternate agent is not willing, able, or reasonably available to make a health care decision for me, I designate the following individual as my second alternate agent:

_____

(Name of Individual chosen as Alternate Agent) (Relationship)

_____

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

_____

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

(6) EXCLUDING INVOLVEMENT OF UNWANTED PERSONS *(optional):*

☐ I Do Not want the following person(s) to have any participation or influence in regards to my health care decisions:

- _____
- _____
- _____
- _____

(7) 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. This advance directive shall not be expired by the appointment of conservator, but will apply in the same manner to the named conservator to take actions in my best interest when making health care decisions on my behalf.

(8) PROTECTION OF THIRD PERSONS FROM LIABILITY: No person or organization who relies on the authority of my agent under this Advance Health Care Directive shall incur any liability to me, my estate, or beneficiaries because of such reliance. My agent and alternate agents will not incur any liability for acting or refraining to act under this Advance Health Care Directive in good faith. No licensed physician who executes a medical opinion of incapacity shall be subject to liability because of such opinion.

Part 2 Instructions for Health Care

Part 2 of this form allows you to state what medical treatments you would want if you are unable to make your own health care decisions. You may choose to mark your preferences on this form and/or add any additional instructions to clarify your wishes more clearly. You also have the option to designate a primary physician.

(1) END OF LIFE DECISIONS**:** I direct that my primary physician and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have marked below: **(initial only one box)**

Close to Death: If my primary physician decides that I am likely to die within a short period of time and life-support treatment would only delay the moment of my death: **(initial only one box)**

[ ] I want to have life-support treatment.

[ ] I do not want life-support treatment. If it has been started, I want it stopped.

[ ] I want to have life-support treatment if my primary physician believes it would help. But I want it stopped, if it is not helping my health condition or symptoms.

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In a Coma: If my primary physician decides that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life support treatment would only delay the moment of my death:
(initial only one box)

[ ] I want to have life-support treatment

[ ] I do not want life-support treatment; if it has been started I want it stopped.

[ ] I want life-support treatment if my primary physician believes it will help, but I want it stopped, if it is not helping my health condition or symptoms.

Permanent and Severe Brain Damage: If my primary physician decides that I have permanent and severe brain damage (for example, I can open my eyes, but I cannot speak or understand – persistent vegetative state) and am not expected to get better, and life support would only delay the moment of my death:
(initial only one box)

[ ] I want to have life support treatment.

[ ] I do not want to have life-support treatment; if it has been started, I want it stopped.

[ ] I want to have life-support treatment if my primary physician believes it would help. But I want it stopped if it is not helping my health condition or symptoms.

End Stage Alzheimer's Disease or Other Dementias: When my primary physician believes the disease process has reached end stage and I am unable to, or have difficulty in, swallowing, or I choke when swallowing, and placing a feeding tube would only prolong my life: **(initial only one box)**

[ ] I want a feeding tube placed.

[ ] I do not want a feeding tube placed.

Other Choices **NOT** to Prolong Life: If there are any other conditions for which I do not want to have life-support treatment, I describe them here: _____

_____

_____

Other Wishes Of Mine (*strike out any wording you do not want*)

- I do not want to be in pain. I want my primary physician to give me enough medicine to relieve my pain even if that means I will be sleepy or drowsy and even if it may hasten my death.
- I want to be kept clean, comfortable, and warm.
- I want good mouth care and my lips kept moist.
- I want to visit with all members of my family and friends who may desire to spend time with me, except: _____.
- I wish to die on Hospice Care, whether I am at home, in a skilled nursing or assisted living facility, if at all possible. Additional comments: _____

(2) OTHER HEALTH CARE WISHES *(i.e. no blood transfusions, etc.):*

_____

_____

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(3) PRIMARY PHYSICIAN (*optional*): I designate the following physician as my primary physician:
Name of Physician: _____
Address: _____ Phone: _____

Part 3 Signatures and Witnesses

(1) YOUR SIGNATURE FOR ADVANCE HEALTH CARE DIRECTIVE:

By my signature I confirm that I have read and understand this Advance Health Care Directive. I recognize that Hospice Touch provides this community service to facilitate the process of advance care planning and no legal counsel or medical advice has been offered to me in connection with completion of this document by any representative of Hospice Touch.

Effect of a copy: A copy of this form has the same effect as the original.

→ **Sign Your Name:** _____ **Date:** _____**Date of Birth:** _____
Print your name: _____
If you are physically unable to sign your name, it is acceptable to place a mark of "**X**" here: _____

(2) WITNESSES: This advance health care directive will not be valid for making health care decisions unless it is **either**:

- Acknowledged before a notary public.
- Signed by two (2) qualified adult witnesses who are present when you sign or acknowledge your signature. All parts of the Statement of Witnesses below must be true.

Statement of Witnesses

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA

- 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.
- That the individual signed or acknowledged this advance health care directive in my presence.
- That the individual signed or appears to be of sound mind and under no duress, fraud or undue influence.
- That I am not a person appointed as an agent by this advance health care directive.
- That I am not the individual's health care provider, an employee of the individual's health care provider, an employee or an operator of a community care facility, nor an employee or an operator of a residential care facility for the elderly.
- I declare I am age18 or older.

Signature of Witness #1 Date	Signature of Witness #2 Date
Printed Name of Witness #1	Printed Name of Witness #2
Address	Address

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 the State of California, that I am not related to the individual executing this advance health care 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 Date

This Advance Health Care Directive has been created in accordance with the Health Care Decisions Law, Section 4600-4805 of the California Probate Code.

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(3) SPECIAL WITNESS REQUIREMENT: If 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:

Signature: _____ Date: _____

Print Name: _____

Address: _____

(4) CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC (*not required if signed by two witnesses)*

State of California, County of _____ On this _____ day of _____ , before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal. Seal

Signature _____

MAKE COPIES OF THIS ADVANCE DIRECTIVE AND GIVE TO YOUR AGENT(S), YOUR PRIMARY PHYSICIAN, AND ANY FAMILY MEMBERS WHO MAY NEED IT. <u>DO NOT</u> PUT THIS IN A SAFE DEPOSIT BOX, OR A PLACE NO ONE WILL KNOW WHERE TO LOOK FOR IT.

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Definitions

Advance Health Care Directive or Advance Directive:

An individual health care instruction or a power of attorney for health care.

Agent:

An individual designated under a power of attorney for health care to make a health care decision for another person.

Alzheimer's Disease:

A form of dementia due to shrinkage of frontal and occipital lobes of the brain. Involves progressive, irreversible loss of memory and deterioration of intellectual functions.

Antibiotics:

Drugs used to fight infection (for example, pneumonia).

Artificial Hydration/Nutrition:

The provision of nutrients and fluids through tubes inserted into the gastrointestinal tract or vein (IV) when a person is permanently or temporarily unable to take nutrition. Also referred to as Artificial Fluids/ Artificial Feeding.

Artificial Ventilation:

A breathing tube inserted through the mouth or nose into the lung, then connected to a breathing machine (ventilator) for a person unable to breathe.

Brain Death:

The irreversible loss of all functions of the brain, including the brain stem.

Capacity:

A person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives.

Coma:

A profound state of unconsciousness, often the result of trauma, infection, and diseases.

Comfort Care:

Care given to improve the quality of life of patients who have a serious or life-threatening disease. Providing relief of symptoms (pain, nausea etc.) of a disease process, with no curative treatment modalities.

Conservator:

A court-appointed person (conservator) having authority to make a health care decision for a patient.

CPR (Cardiopulmonary Resuscitation):

A medical procedure often involving external chest compression, drugs, respiratory support, and electric stimulation used to restore the heartbeat and breathing.

Definitions (continued):

Dialysis:

A machine used to cleanse the blood when the kidneys cannot function normally.

DNR (Do Not Resuscitate):

An order not to provide CPR. Does not include other end-of-life treatment decisions.

End-Stage:

The final phase of a disease process.

Feeding Tube:

A tube placed down the nose into the stomach (or directly into the stomach by surgical means) which provides artificial nutrition/hydration.

Life-support or Life-sustaining Treatments:

Any medical procedure, device, or medication to prolong life, including CPR, breathing machines, tube feedings, major surgery, blood transfusions, dialysis, antibiotics.

Persistent Vegetative State:

An irreversible condition where wakefulness and sleep cycles are present, as well as other basic body functions, but the person is totally unconscious, unaware of the environment and unable to experience pain.

Primary Physician:

A physician designated by a patient or the patient's agent to have primary responsibility for the patient's health care or, in the absence of a designation or if the designated physician is not reasonably available, or declines to act as primary physician, a physician who undertakes that responsibility.

Quality of Life:

The features of an individual's life that give it meaning and value.

Surrogate:

An adult, other than a patient's agent or conservator, authorized to make a health care decision for the patient.

Terminal Illness:

A condition when, in spite of medicine's best efforts, it is clear a patient will die.

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Health History Information – Optional

Today's Date: _____

Name: _____

Emergency Contact: _____
Address: _____
_____
Phone: _____

Primary Care Physician / Phone: _____ / _____
Other Physician / Phone: _____ / _____

Allergies: _____
_____
_____

Blood Type: _____

Significant Health Conditions: _____
_____
_____
_____

Significant Surgeries / Hospitalizations: _____
_____
_____
_____

Routine Medications: _____
_____
_____
_____

Advance Directive Agent: _____ **Relationship:** _____
Address: _____ **Phone:** _____
_____

Health Insurance Information: _____
Policy Number: _____

Religious Affiliation: _____

Additional Information: _____
_____

HOSPICETOUCH