

# Advance Health Care Directive



## LIFE CARE **planning**

my values, my choices, my care

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# LIFE CARE planning

my values, my choices, my care

Full name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

## Introduction

This Advance Health Care Directive allows you to share your values, your choices, and your instructions about your future health care. This form may be used to:

- Name someone you trust to make health care decisions for you (your health care agent), OR
- Provide written instructions about your future health care, OR
- Both name a health care agent AND provide written instructions for future health care.

**Part 1** allows you to name a health care agent.

**Part 2** gives you an opportunity to share your values and what is important to you.

**Part 3** allows you to give written instructions about your future health care.

**Part 4** allows you to guide your agent's decision making by stating your hopes and wishes.

**Part 5** allows you to make your Advance Health Care Directive legally valid in the State of California.

**Part 6** prepares you to share your wishes and this document with others.

You are free to modify this form or use a different form.

This Advance Health Care Directive will replace any Advance Health Care Directive you have completed in the past. In the future, if you want to cancel or change your named agent, you must do so in writing and sign that document, or you can inform your health care provider in person.

Full name: \_\_\_\_\_

Medical Record number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Full name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

## Part 1. My Health Care Agent

### *Selecting a health care agent:*

*Choose someone who knows you well, who you trust to honor your views and values, and who is able to make difficult decisions in stressful situations. Once you have selected your health care agent, take the time to discuss your views and treatment goals with that person.*

If I am unable to communicate my wishes and health care decisions, or if my health care provider has determined that I am not able to make my own health care decisions, I choose the following person(s) to represent my wishes and make my health care decisions.\*

My health care agent must make health care decisions that are consistent with my instructions in this document and my known desires. If my agent does not know my wishes, my agent must make health care decisions that he or she believes to be in my best interest, considering what he or she knows about my personal values.

This form does not give my health care agent the authority to make financial or other business decisions. My health care agent does not have the power to place me in a mental health treatment facility or consent to some types of mental health treatments.

### **My primary (main) health care agent is:**

Full name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing address: \_\_\_\_\_

\*I understand that my health care agent cannot be my supervising health care provider or an operator of a community or residential care facility where I am receiving care. My agent also may not be an employee of a community care, residential care, or health care facility where I am receiving care, unless that person is my relative by blood, marriage, or adoption, is my registered domestic partner, or is my coworker.

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Full name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

If I cancel my primary health care agent's authority, or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name the individuals below as my first and second alternate agents.

**First alternate health care agent:**

Full name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing address: \_\_\_\_\_

**Second alternate health care agent:**

Full name: \_\_\_\_\_ Relationship to me: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing address: \_\_\_\_\_

**Powers of my health care agent:**

**Unless I state otherwise, my health care agent has all of the following powers** when I am unable to speak for myself or make my own decisions:

- A. Make choices for me about my health care. This includes decisions about tests, medicine, and surgery. It also includes decisions to provide, not provide, or stop all forms of health care to keep me alive, including artificial nutrition (food) and hydration (water).
- B. Review and release my medical records as needed to make decisions.
- C. Decide which physician, health providers, and organizations provide my medical treatment.
- D. Arrange for and make decisions about the care of my body after death (including autopsy).

Full name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

*Please provide any additional comments or restrictions to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify decisions you would not want your agent to make.) Attach additional page(s) if necessary.*

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**Additional powers of my health care agent:**

*Check the box or boxes below, if you want your agent to have any of the following powers.*

- I want my agent to continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership has been completed.
  
- I want my agent to immediately begin making health care decisions for me even if I am able to decide or speak for myself.

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## Part 2. My Values

I want my agent and loved ones to know what matters most to me, so that they can make decisions about my health care that match who I am and what is important to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, who I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

### 1. If I were having a really good day, I would be doing the following:

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### 2. What matters most to me is:

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### 3. Life would no longer be worth living if I were not able to:

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### Part 3. My Health Care Instructions: My Choices, My Care

In the situation below, we ask you to consider a sudden unexpected event. You will always speak for yourself if you are able; in this situation you are unable to speak for yourself.

If I become unable to communicate or make my own choices, I ask that my health care agent represent my choices as detailed below, and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are unable to make decisions on my behalf, this document represents my wishes.

*Note: If you choose not to provide written instructions, your health care agent will make decisions based on your spoken directions. If your directions are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.*

#### 1. Treatments to prolong life

##### Consider the following situation:

You have a sudden accident or stroke.

Doctors have determined you have a brain injury, leaving you unable to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine), or a feeding tube, etc., are required to keep you alive. In this situation what would you want?

##### I would want to be kept comfortable and:

- Choose One
- I would want to STOP life-sustaining treatment. I realize this would probably lead me to die sooner than if I were to continue treatment.
  - I would want to continue life-sustaining treatments.

*Please provide any additional instructions about life-sustaining treatments. For example, you may want to state a specific time period that you would want to be kept alive if there were no improvement to your health.*

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## 2. CPR (Cardiopulmonary resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.\* If you would like additional information about CPR, please request the brochure called **CPR: My Choice**.

### In the event that your heart and breathing stop, what would you want?

Choose  
One

- I always want CPR attempted.
- I never want CPR attempted, but rather, want to permit a natural death.\*\*
- I want CPR attempted unless the doctor treating me determines any of the following:
  - I have an incurable illness or injury and am dying; or
  - I have no reasonable chance of survival if my heart or breathing stops; or
  - I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause significant suffering.

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\*Research shows that if you are in a hospital and get CPR, you have a 17 percent chance of it working and you leaving the hospital alive. Peberdy MA, Kaye W, Ornato JP, et al. Cardiopulmonary resuscitation in adults in the hospital: A report of 14,720 cardiac arrests from the National Registry of Cardiopulmonary Resuscitation. Resuscitation - 2003; 58 297-308.

\*\*If you are certain you do not want CPR, please discuss other documents you may want to complete with your physician.



## Part 4. My Hopes and Wishes (Optional)

### 1. My thoughts and feelings about where I would prefer to die:

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### 2. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, rituals, music, etc.):

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### 3. Religious or spiritual affiliation:

I am of the \_\_\_\_\_ faith, and am a member of (faith/spiritual community) \_\_\_\_\_ in (city) \_\_\_\_\_, (phone #) \_\_\_\_\_. I would like my agent to notify them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

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Full name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

## Part 4. My Hopes and Wishes (Optional)

4. Organ donation (If you have no preference, your agent may decide for you.):

Upon my death, I want to donate my eyes, tissues, and any organs. My specific wishes (if any) are:

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Upon my death, I only wish to donate the following organs, tissues, or body parts:

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I DO NOT want to donate my eyes, tissues, and/or organs.

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5. If you wish to donate your body for research, arrangements must be made in advance:

Organization/Institution Name: \_\_\_\_\_ Phone: \_\_\_\_\_

6. Other wishes/instructions:

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## Part 5. Making This Document Legally Valid

To make your Advance Health Care Directive legally valid in California, it must be signed by two witnesses, OR acknowledged before a Notary Public. Follow the steps outlined below in the order in which they are listed:

### 1. Choose EITHER

#### Two Witnesses



- One of your witnesses cannot be related to you (by blood, marriage, or adoption) and cannot be entitled to any part of your estate.
- When you are with your witnesses, sign or acknowledge your signature.
- Witnesses will sign on page 11.
- You will sign on page 12.

OR

#### Notary Public



- Do NOT sign this document unless you are with a Notary Public.
- Notary Public will sign on page 12. (Skip page 11.)
- You will sign on page 12.

### 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 an ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

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

Full name: \_\_\_\_\_  
Medical Record #: \_\_\_\_\_

***This form must be signed by two witnesses (only one of whom can be related to you), OR acknowledged before a Notary Public. If using a Notary Public, skip this page.***

### Statement of Witnesses

**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 appears to be of sound mind and under no duress, fraud, or undue influence,
- that I am not appointed as an agent by this Advance Health Care Directive, and
- 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, or an employee of an operator of a residential care facility for the elderly.

#### Witness Number One:

Print full name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Witness Number Two:

Print full name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ADDITIONAL STATEMENT OF WITNESS:** At least one of the witnesses must meet the following requirements and 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 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.

Print full name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Full name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**MY SIGNATURE**

My name printed: \_\_\_\_\_

**My Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you are physically unable to sign, any mark you make that you intend to be your signature is acceptable.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

**Notary Public**

State of California

County of \_\_\_\_\_

on \_\_\_\_\_ before me, \_\_\_\_\_,  
Date Name and Title of Officer

personally appeared \_\_\_\_\_  
Name of Signer

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 \_\_\_\_\_ (Seal)

## Part 6. Next Steps

Now that you have completed your Advance Health Care Directive, you should also take the following steps.

### Discuss:

- Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to perform this important job for you in the future.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.

### Give copies:

- Give your health care agent a copy of your Advance Health Care Directive.
- Give a copy of your Advance Health Care Directive to your doctor, or your local Kaiser Permanente Education Department.
- Make a copy for yourself and keep it where it can be easily found.

### Take with you:

- If you go to a hospital or nursing home, take a copy of your Advance Health Care Directive and ask that it be placed in your medical record.
- Take a copy with you any time you will be away from home for an extended period of time.

### Review regularly:

- Review your health care wishes whenever any of the "Five D's" occur:
  - Decade** – when you start each new decade of your life.
  - Death** – whenever you experience the death of a loved one.
  - Divorce** – when you experience a divorce or other major family change.
  - Diagnosis** – when you are diagnosed with a serious health condition.
  - Decline** – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

### Changing your Advance Health Care Directive:

If your wishes change, fill out a new Advance Health Care Directive and tell your agent, your family, and provide a copy to Kaiser Permanente.

Full name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Copies of this document have been given to:**

- Primary (Main) Health Care Agent

Full name: \_\_\_\_\_

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

- Alternate Health Care Agent #1

Full name: \_\_\_\_\_

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

- Alternate Health Care Agent #2

Full name: \_\_\_\_\_

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

- Health Care Provider/Clinic

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

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

- Others:

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

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

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This information is not intended to diagnose health problems or to take the place of medical advice or care you receive from your physician or other health care professional. If you have persistent health problems, or if you have additional questions, please consult with your doctor.

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