

ADVANCE DIRECTIVE

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Patient Name: _____

Patient Phone Number: _____

ADVANCE HEALTH CARE DIRECTIVE

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.

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 an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state 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 a 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.

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 providers 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 limits of generally accepted health care standards.

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, or 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 give any needed organs, tissues, or parts

_____ (*Initial here*)

OR

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

_____ (*Initial here*)

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

My gift is for the following purposes:

_____ (*Initial here*) Transplant

_____ (*Initial here*) Research

_____ (*Initial here*) Therapy

_____ (*Initial here*) Education

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 transplants outside of the United States.

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

_____ (*Initial here*) Yes

_____ (*Initial here*) No

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

_____ (*Initial here*) Yes

_____ (*Initial here*) No

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

_____ (*Initial here*) Yes

_____ (*Initial here*) No

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

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

SIGNATURE:

Sign and date the form here

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____
(patient)

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 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

Telephone: _____

Address: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

SECOND WITNESS

Telephone: _____

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 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.

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(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, (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: _____ [Seal]
(notary)

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

Date: _____ Time: _____ AM / PM

Signature: _____
(patient advocate or ombudsman)

Print name: _____
(patient advocate or ombudsman)

Address: _____