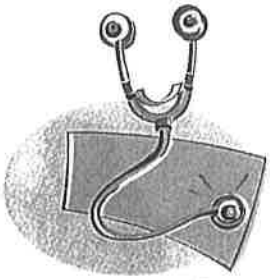
California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.



- **This form has 3 parts. It lets you:**

Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want. Always sign the form in Part 3.
2 witnesses need to sign on page 10 or a notary public on page 11.

YOUR NAME: _____

Go to the next page

If you only want a health care agent go to **Part 1** on page 3.

If you only want to make your own health care choices go to **Part 2** on page 6.

If you want both then fill out **Part 1 and Part 2.**

Always sign the form in Part 3 on page 9.

2 witnesses need to sign on page 10 or a notary public on page 11.

What do I do with the form after I fill it out?

Share the form with those who care for you:

- doctors
- nurses
- social workers
- family & friends
- health care agent

What if I change my mind?

- Fill out a new form.
- Tell those who care for you about your changes.
- Give the new form to your health care agent and doctor.

What if I have questions about the form?

- Bring it to your doctors, nurses, social workers, health care agent, family or friends to answer your questions.

What if I want to make health care choices that are not on this form?

- Write your choices on a piece of paper.
- Keep the paper with this form.
- Share your choices with those who care for you.

PART 1 Choose your health care agent

The person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my health care agent?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your agent cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

If you want your agent to be someone other than family, you must write his or her name on this form.

What kind of decisions can my health care agent make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications, tests, or treatments
- what happens to your body and organs after you die

Your agent will need to follow the health care choices you make in Part 2.

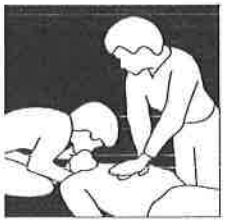
Go to the next page

Other decisions your agent can make:

Life support treatments - medical care to try to help you live longer

- **CPR or cardiopulmonary resuscitation**

  cardio = heart pulmonary = lungs resuscitation = to bring back



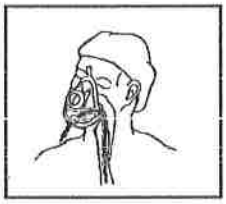
This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins

- **Breathing machine or ventilator**

  The machine pumps air into your lungs and breathes for you.

  You are not able to talk when you are on the machine.



- **Dialysis**

  A machine that cleans your blood if your kidneys stop working.

- **Feeding Tube**

  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **Blood transfusions**

  To put blood in your veins.

- **Surgery**
- **Medicines**

End of life care - if you might die soon your health care agent can:

- call in a spiritual leader
- decide if you die at home or in the hospital

Show your health care agent this form.

Tell your agent what kind of medical care you want.

Go to the next page

Your Health Care Agent

I want this person to make my medical decisions.

first name last name

street address city state zip code

( ) – ( ) –

home phone number work phone number

If the first person cannot do it, then I want this person to make my medical decisions.

first name last name

street address city state zip code

( ) – ( ) –

home phone number work phone number

Put an X next to the sentence you agree with.

❑ My health care agent can make decisions for me right after I sign this form.

❑ My health care agent will make decisions for me **only** after I cannot make my own decisions.

You may write down your health care choices on this form. How do you want your health care agent to follow these choices? Put an X next to the one sentence you most agree with.

❑ I want my health care agent to work with my doctors and to use her/his best judgment. It is OK for my agent to follow my health care choices on this form as a **general guide**.

Even though it is OK to follow my choices as a general guide, there are some choices I do not want changed:

❑ I want my health care agent to follow my health care choices on this form **exactly**. I never want my agent to change my choices, even if the doctors think this is not good for me.

To make your own health care choices go to Part 2 on the next page.

To sign this form go to Part 3 on page 9.

PART 2 Make your own health care choices

Write down your choices so those who care for you will not have to guess.

- **Think about what makes your life worth living.**

  ❑ **My life is only worth living if I can:**
  Put an X next to all the sentences you most agree with.

  - ○ talk to family or friends
  - ○ wake up from a coma
  - ○ feed, bathe, or take care of myself
  - ○ be free from pain
  - ○ live without being hooked up to machines
  - ○ I am not sure

  or

  ❑ **My life is always worth living no matter how sick I am**

- **If I am dying, it is important for me to be:**

  ❑ at home ❑ in the hospital ❑ I am not sure

- **Is religion or spirituality important to you?**

  ❑ no ❑ yes If you have one, what is your religion?

  _____

- **What should your doctors know about your religion or spirituality?**

  _____

  _____

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

Go to the next page

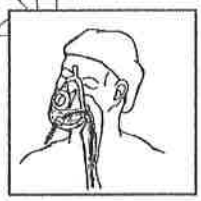
Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Put an X next to the one choice you most agree with.
Please read this whole page before you make your choice.

If I am so sick that I may die soon:

❑ Try all life support treatments that my doctors think might help.

If the treatments **do not work** and there is little hope of getting better, **I want to stay** on life support machines.



or

❑ Try all life support treatments that my doctors think might help.

If the treatments **do not work** and there is little hope of getting better, **I do not want to stay** on life support machines.

or

❑ Try all life support treatments that my doctors think might help **but not** these treatments. Mark what you do not want.

- ○ CPR
- ○ dialysis
- ○ breathing machine
- ○ feeding tube
- ○ blood transfusion
- ○ medicine
- ○ other treatments _____

or

❑ I **do not want any** life support treatments.

or

❑ I want my **health care agent** to decide for me.

or

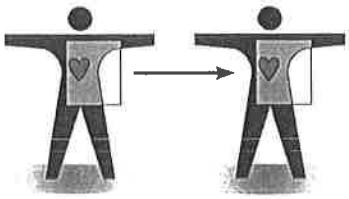
❑ I am not sure.

Go to the next page

Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

Put an X next to the one choice you most agree with.

Donating (giving) your organs can help save lives.



- ❑ I **want** to donate my organs.

  Which organs do you want to donate?

  - ○ any organ
  - ○ only_____

- ❑ I **do not** want to donate my organs.
- ❑ I want my **health care agent** to decide.
- ❑ I am not sure.

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

- ❑ I **want** an autopsy.
- ❑ I **do not** want an autopsy.
- ❑ I want an autopsy if there are questions about my death.
- ❑ I want my **health care agent** to decide.
- ❑ I am not sure.

What should your doctors know about how you want your body to be treated after you die?

_____

_____

Go to Part 3 on the next page to sign this form

PART 3 Sign the form

Before this form can be used, you must:

- sign this form
- have two witnesses sign the form

If you do not have witnesses, a notary public must sign on page 11.

A notary public's job is to make sure it is you signing the form.

Sign your name and write the date.

_____ / / _____

sign your name date

_____

print your first name print your last name

_____

address city state zip code

Your witnesses must:

- be over 18 years of age
- know you
- see you sign this form

Your witnesses cannot:

- be your health care agent
- be your health care provider
- work for your health care provider
- work at the place that you live (if you live in a nursing home go to page 12)

Also, one witness cannot:

- be related to you in any way
- benefit financially (get any money or property) after you die

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public and have them sign on page 11.

Have your witnesses sign their names and write the date

By signing, I promise that _____ signed this form while I watched.
(name)

He/she was thinking clearly and was not forced to sign it.

I also promise that:

- I know him/her or this person could prove who he/she was
- I am 18 years or older
- I am not his/her health care agent
- I am not his/her health care provider
- I do not work for his/her health care provider
- I do not work where he/she lives

<u>One</u> witness must also promise that:

- I am not related to his/her by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after he/she dies

Witness #1

_____ / / _____

sign your name date

_____

print your first name print your last name

_____

address city state zip code

Witness #2

_____ / / _____

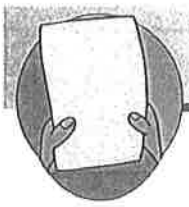
sign your name date

_____

print your first name print your last name

_____

address city state zip code



You are now done with this form.

Share this form with your doctors, nurses, social workers, friends, family, and health care agent.

Talk with them about your choices.

NOTARY PUBLIC

- Take this form to a notary public **ONLY** if two witnesses have not signed this form.
- Bring photo I.D. (driver's license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California

County of _____

On _____ (Date) before me, _____ (Here Insert 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.

Signature _____ (Signature of Notary Public)

Description of Attached Document

Title or Type of document: _____

Date: _____ Number of pages: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____

☐ Individual

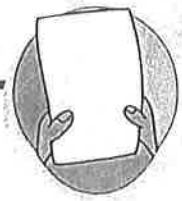
☐ Guardian or conservator

☐ Other _____

RIGHT THUMBPRINT OF SIGNER
Top of thumb here

(Notary Seal)

You are now done with this form.



Share this form with your doctors, nurses, social workers, friends, family, and health care agent.

Talk with them about your choices.

For California Nursing Home Residents ONLY

- **Give this form to your nursing home director only if you live in a nursing home.**
- **California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.**

STATEMENT OF THE 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."

_____ / / _____

sign your name date

print your first name print your last name

address city state zip code

This advance directive is in compliance with the California Probate Code, Section 4671-4675. http://www.leginfo.ca.gov/calaw.html

Revised 1/18/2010

Designed by Rebecca Sudore, MD & Mahat Papartassee for the San Francisco Department of Public Health