INFORMATION FOR PATIENTS

Advance Health Care Directive Kit

A guide to help you express your health care wishes

UCSF Medical Center

UCSF Benioff Children's Hospital

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PART I - REQUIRED Selection of a decision maker
Who will make health care decisions for you if you can't speak for yourself?

- This form is called an Advance Health Care Directive. Filling out any form can take time and sometimes can be overwhelming. **If you have limited time, the most important thing to do is to complete pages 1, 6, 7 and 8 which allows you to:**
  - Choose someone to make health care decisions for you if you are not able or do not wish to make these decisions for yourself **AND, if you have time**:
  - You may wish to write down your values and wishes for how you want to be taken care of if you cannot speak for yourself because of serious illness.
- If you change your mind about anything on this form, you may fill out a new form or destroy (revoke) the old form.
- As you complete this form, please talk to your decision maker to be sure the decision maker understands your wishes and agrees to accept this responsibility. You should also discuss your health care wishes with your loved ones and health care team. **Your decision maker cannot make decisions for you until you are unable or do not wish to make these decisions for yourself**.
- Once this form is filled out and properly signed it is valid in California and under the laws of most states. To be valid, it must be signed in the presence of two witnesses or acknowledged by a notary public (see page 8).

PART I *Lets you:*

Appoint another person to make health care decisions if you are unable to make your own decisions. Under California law, this person is called an "agent". For suggestions on how to choose the right person, see frequently asked questions on page 9.

It is important that your appointed decision maker be independent of your health care team. Your decision maker may **NOT** be any of the following:

- Your doctor or any other member of your health care team.
- The operator of a community care or residential care facility where you receive care.
- An employee of the health care institution or community residential facility.

I ____ , choose the
(your name and date of birth)

following person as my health care decision maker:

Name: ____

Address: ____

City: ______________________ State: ________ ZIP: ________

Home phone: ______________________ Work phone: ______________

Email: ____

OPTIONAL *If my decision maker is not willing or able to make decisions for me, then I choose the following person:*

Name: ____

Address: ____

City: ______________________ State: ________ ZIP: ________

Home phone: ______________________ Work phone: ______________

Email: ____

Your appointed decision maker cannot make decisions for you until you are unable or do not wish to make these decisions for yourself.

Your appointed decision maker's authority (See PART II below)

If you choose not to limit the authority of your decision maker, your decision maker will have the right to:

- Talk to your health care team about how you are doing.
- Accept, refuse or stop any medical care.
- See and approve of the release of your medical records or health care information.
- Choose health care providers and institutions.
- Determine how your body will be cared for after you die, including autopsy and organ donation.
- NOTE: Your decision maker cannot consent to placing you in a mental health hospital or to convulsive treatment, invasive psychiatric treatment, sterilization or abortion.

PLEASE CROSS OUT AND INITIAL anything listed above that you do not want your decision maker to do.

PART II - OPTIONAL

Your appointed decision maker's authority to make health care decisions

You may or may not choose to limit the authority of your decision maker.

Listed below are any additions or other instructions on my decision maker's powers:

____

____

____

____

____

PART III - OPTIONAL

Special instructions for how you wish to be taken care of if you become seriously ill

If you do not wish to provide specific, written guidance, please CROSS OUT AND INITIAL THIS PAGE.

If none of these statements represent your beliefs and values, SEE THE NEXT PAGE FOR OTHER OPTIONS. →

You may wish to give your decision maker and health care team some additional guidance about your beliefs, values and wishes. Below are examples of what you might consider discussing with your appointed decision maker. Check any of these statements if they represent your beliefs, wishes and values if you become seriously ill.

If I have a medical condition that will cause me to die within a short period of time and/or my quality of life will be poor AND life support (such as a medical procedure, CPR**, breathing tube, tube for artificial nutrition and hydration, machine or medication) is needed to keep me alive:

- ☐ I want to have life support***
- ☐ I do not want life support and wish to be allowed to die a natural death
- ☐ I want my decision maker to decide with my health care team if life support would help my condition or symptoms

☐ When my health care team has said that my condition is incurable or that I will probably not return to a level of health that I have had in the past (poor quality of life), I wish to get care focused on helping my symptoms (comfort care*) instead of care focused on prolonging my life. Please refer me to hospice*.

***What is comfort care?** *Your health care providers focus on relief of your symptoms rather than cure. Comfort care offers support for the whole person and those who are involved in your life. Such care is also offered by your health care team and hospice organizations to which you may be referred by your health care team.*

****What is CPR?** *Cardiopulmonary Resuscitation can involve a number of actions done in an emergency to get oxygen into your body and make sure that blood reaches your heart and brain. Your chest may be forcefully pressed, an electric shock (defibrillation) may be used, a tube may be put through your mouth into your windpipe to help you breathe, or you may be injected with drugs in an attempt to return your heart rhythm and blood pressure back to normal. CPR will not cure a disease. Most patients who have CPR are not able to function as they used to.*

*****What is life support?** *Treatments such as a medical device to help you breathe; medication to keep you alive: artificial nutrition and fluids given with a tube; major surgery; blood transfusions; dialysis; antibiotics; or anything else meant to delay your death.*

PART III - OPTIONAL

Special instructions for how you wish to be taken care of if you become seriously ill (continued)

If you do not wish to provide specific, written guidance, please CROSS OUT THIS PAGE.

Some people want to give very specific instructions for how they wish to be treated if they become seriously ill. Some people want to have their decision maker use good judgment and work with the health care team. If you decide to write specific instructions here are some possible topics (listed to the right):

- Persons with whom you want, or do not want, your decision maker to consult.
- What you see as quality of life, for example:
  - Independence
  - Ability to enjoy friends, family and daily activities
  - Basic life skills, like eating, moving, and bowel and bladder control
  - Being free from pain and suffering
  - The good days outweigh the bad
- Support from your faith community.
- Treatment for pain or discomfort even if it means it could hasten your death or make you sleep more.
- Desire as to whether you wish to die at home, in the hospital or in hospice.

PART IV - OPTIONAL
Organ and tissue donation

- A clear statement of your wishes about organ and tissue donation will help make sure that your decisions are honored.
- You may name specific organs and tissues such as eyes, organs (kidney liver, heart valve) or tissue.
- You may also register your decision about organ donation when you renew your driver's license and/or sign up at **www.donateLIFEcalifornia.org**.

UPON MY DEATH:

☐ I wish to donate ANY needed organs, tissues or body parts _____ (initial)

OR

☐ I wish to donate ONLY the following organs, tissues or body parts _____ (initial):

____

____

I wish my organs or tissue to be used for:

_____ transplantation or therapy

_____ medical education and research

_____ either of the above

OR

☐ I do NOT wish to donate any organs, tissue, or parts. _____ (initial)

OR

☐ I would like my decision maker to decide if any of my organs or tissues are donated except as stated here:

____

____

PART V - REQUIRED Signature and witness

To be a valid Advance Health Care Directive you must sign this document and either have it witnessed by two people according to the instructions below OR have it acknowledged before a notary public (See page 8).

- If you are physically unable to sign, any mark you make that you intend to be your signature is acceptable.
- Witnesses should watch while you sign your name. The date you sign this form should be the same as the date that your witnesses sign this form.

SIGNATURE Sign and date this form here:

____
(Print your name)

____
(Sign your name) *(Date)*

Address: ______________________________

City: ______________ **State:** ________ **ZIP:** ________

Statement of witnesses

Please note who cannot act as a witness

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 Health Care 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 a decision maker (agent) by this Advance Health Care Directive; and (5) that I am not the individual's health care provider nor an employee of that health care provider, nor an operator or employee of an operator of a community care facility or residential care facility for the elderly.

FIRST WITNESS

____
(Print your name)

____
(Sign your name) *(Date)*

Address: ______________________________

City: ______________________________

State: ________ **ZIP:** ________

SECOND WITNESS

____
(Print your name)

____
(Sign your name) *(Date)*

Address: ______________________________

City: ______________________________

State: ________ **ZIP:** ________

PART V - REQUIRED Signature and witness (continued)

To be a valid Advance Health Care Directive you must sign this document and either have it witnessed by two people according to the instructions below OR have it acknowledged before a notary public (see the next two pages).

At least one of the 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 not existing or by operation of law.

Signature of one witness:

____

(Signature of one witness) *(Date)*

For patients in skilled nursing facilities: statement of patient advocate or ombudsman

If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the statement of witnesses on the previous page and must also sign the following declaration:

I further 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 am serving as a witness as required by Probate Code section 4675.

Print name/Title: ____

Address: ____

____

(Signature) *(Date)*

PART VI - REQUIRED Acknowledgment of notary public (Necessary only if two witnesses have not signed on page 6)

Acknowledgement before a notary public is NOT required if two qualified witnesses have signed this directive in PART V

State of California

County of: ______________________________

On: ____________________ before me, ______________________________
(Date) *(Name and title of the officer)*

personally appeared: ______________________________

____
(Names of signers)

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 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 of notary public)

Place notary seal and/or stamp above

Frequently asked questions

1. How do I choose the right person as my decision maker for health care decisions? Sometimes patients find it difficult to decide who they should choose as their decision maker. Patients don't want to hurt their family members' feelings. In choosing your decision maker, please keep in mind the following:

- A spouse or family member is not always the best choice if they are too emotionally involved or they are not able to stand up for you or make decisions so that your wishes are followed.
- Here are some factors to consider. Choose someone who:
  - Has had regular contact with you before and during your illness
  - Is familiar with your wishes and values and will honor those wishes and values
  - Is able to provide information about your health history, wishes and values
  - Is able to understand your medical condition
  - Will be able to make decisions about your care in the middle of an emotional situation
  - Is available to come to the hospital
  - Is able to communicate with your health care team
  - Is able to communicate with your loved ones, receive information from them and share important information with them

2. Do I need an attorney to complete this form? No. The law does not require you to have an attorney.

3. Can I have more than one decision maker? Often many family members are involved in decision making without disagreement. But sometimes people will disagree on the best course of action, so it is best to name just one person who is the representative for the family as your decision maker with a back up decision maker if you wish.

4. How long is an advance health care directive valid? It will continue to be valid unless you decide to cancel or change it.

5. Can I change my mind? You can change your mind at any time. If you change your mind when you are hospitalized, you can tell your doctor who you want to make decisions during that hospitalization.

6. What should I do with this form when it is completed? Make sure it is properly signed according to the instructions on the signature page. Show it to your family, close friends and health care team. A copy of this form is just as valid as the original. Give a copy to your decision maker, physician and health care team and bring a copy of this form with you whenever you go to the emergency room or hospital.

UCSF Medical Center

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