

# California Advance Health Care Directive

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

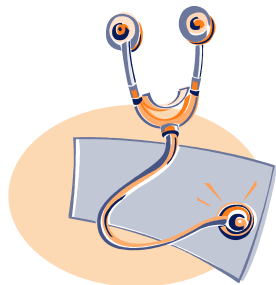


**This form has 3 parts. It lets you:**



**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.**

**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.

### ● 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



### ● What if I change my mind?

- Change the form.
- Tell those that care for you about your changes



### ● What if I have questions about the form?

- Bring it to your doctors, nurses, social workers, 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:



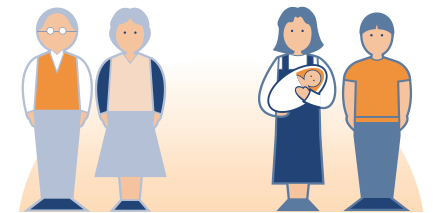
- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form



Your agent **cannot** be your doctor or someone who works at your hospital or clinic, unless they are 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 or tests
- what happens to your body and organs after you die



Go to the next page



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## 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.



# Your Health Care Agent



- I want this person to help 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 help 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 **now**.



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

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.**

Put an X next to **all** the sentences you most agree with.

My life is **only** worth living if I can:

- 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



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?**

- yes                       no

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

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



**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 sentences you most agree with.

Please read this whole page before you make your choices.

### ● 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.



- 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.



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

- |  |   |
|--|---|
| <input type="radio"/> CPR                    | <input type="radio"/> feeding tube      |
| <input type="radio"/> dialysis               | <input type="radio"/> blood transfusion |
| <input type="radio"/> breathing machine      | <input type="radio"/> medicine          |
| <input type="radio"/> other treatments _____ |   |

- I **do not want any** life support treatments.
- I want my **health care agent** to decide for me.
- I am not sure.



## Part 2: Make your own health care choices

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

Put an X next to the sentences you most agree with

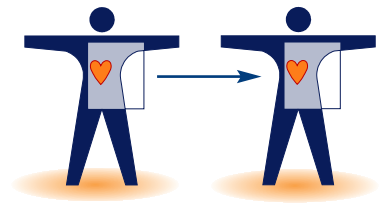
### Donating (giving) your organs can help save lives.

I **want** to donate my organs

Which organs do you want to donate?

any organs

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 may 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?

\_\_\_\_\_

\_\_\_\_\_





# 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, you need a notary public.  
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, doctor, nurse, or social worker.
- benefit financially (get any money) after you die.
- work at the place that you live.  
(if you live in a nursing home, go to page 12)

### Only one witness can be a family member.

The second witness must be someone other than family.

**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 10.**

# Have your witnesses sign their names and write the date



## 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

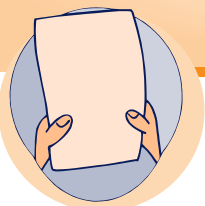
\_\_\_\_\_

state

\_\_\_\_\_

zip code

## You are now done with this form.



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



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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 this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_ before me

\_\_\_\_\_  
(print name of notary public)

personally appeared \_\_\_\_\_  
(print name of person completing this form)

and has proved to me on the basis of satisfactory evidence, to be the person whose name is indicated on this advance health care directive, and has stated that he or she did complete this form. I declare under penalty of perjury, that the person, whose name is indicated in the advance health care directive, appears to be of sound mind and is under no duress, fraud, or undue influence.

NOTARY SEAL

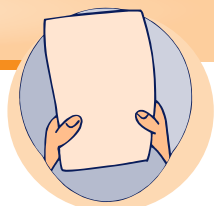
\_\_\_\_\_  
(Signature) (Date)

## You are now done with this form.



**Share this form with your doctors, nurses, social workers, friends, and your family.**

**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 last name

\_\_\_\_\_

city

state

zip code