Basic Guidelines for Using the Advance Health Care Directive Form

Is this AHCD different from a "durable power of attorney for health care" or "declaration to physician?

Yes and no. The other two forms are still valid, unless they have an expiration date, and generally provide for similar directives in case of incapacity. However, the AHCD goes into more detail, adding options that might not have been available on older forms, and is designed to better allow you to express basic values about the care you wish to receive.

Does the AHCD adequately protect my right not to have 911 called, or emergency personnel resuscitate me?

Not necessarily. This specific instruction is best done by a form called "Prehospital Do Not Resuscitate (DNR) Form." This form needs to be signed by your doctor. Emergency medical personnel (EMTs) would prefer you obtain their form, so feel free to call them to get one.

Does my Agent have to be a spouse or family member?

No. It can be anyone you would like who is over 18 years old and of sound mind. Your Agent cannot be connected with the institution in which you live or that provides your health care, unless that person is also your relative.

Do I have to complete every section?

No. If you do not have someone to designate as your Agent, you can still complete the form to express your wishes, or prevent particular people from trying to act as your Agent. If you are not sure how you feel answering the questions in Part 2, you may wish to discuss this with your doctor, Agent, or other trusted persons, but you do not have to complete this section. You can also add additional wishes to the form or by attaching another page. What is important to consider, is that sections unfinished, might leave things to chance. This form is your opportunity to say what you want to happen to you before you become unable to communicate your wishes due to mental or physical illness.

What should I do with the completed form?

Keep the original in a safe place (but not somewhere no one can access if you are unable to get it.) Make copies for and give them to your doctor, your Agent, your alternates, and people named in Parts 4 and 5. Make a list of the people who have copies, so if you revoke or change it, you can be sure and let everyone know. If hospitalized, bring a copy with you. You should fill out and keep in your wallet a "wallet identification card."

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

PURSUANT TO CALIFORNIA PROBATE CODE SECTIONS 4600-4805

- *With this form, you may do any or all of the following:*
  1. *Name an agent to make health care decisions for you if you cannot.*
  2. *Instruct doctors and other care givers how you would like to be treated if you are hurt or seriously ill.*
  3. *Indicate others you would want to play a role in making decisions for you in certain situations.*

- *Read the words carefully. Some sections will not apply unless you initial them. Other parts allow you to cross out wording you do not want. In some sections, you may add more instructions if you wish. Attach extra pages if needed.*

- *After you complete this form, sign and date it in front of two witnesses or a notary. The witnesses or notary must sign, too.*

- *You may revoke anything in this form in writing or by telling your supervising health care provider.*

- *By creating this form, you automatically revoke any contrary instructions in any and all prior directives you made. However, provisions in a prior directive may remain in force if you do not change them in a new one.*

- *Copies of an advance health care directive are as valid as the original. Agents and alternates should have copies with them.*

FULL NAME OF THE PERSON MAKING THIS DIRECTIVE:_____

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

This part of the form allows you to name an Agent, someone to make certain health care decisions for you when you cannot. Even if you do not name an Agent, you may prohibit individuals you name from making such decision for you.

A. **DESIGNATION OF AN AGENT AND ALTERNATES**

I designate the following individual as my Agent to make health care decisions for me on my behalf:
Name_____Address_____
City/State/Zip Code_____
Telephone: (H)_____ (W)_____Cell/Pager_____
If I revoke the authority of my Agent or if my Agent is not willing, able or reasonably available to make health care decisions for me, I designate as my Alternate Agent(s), in the following order:
1.Name_____Address_____
City/State/Zip Code_____
Telephone: (H)_____ (W)_____ Cell/Pager_____
2.Name_____Address_____
City/State/Zip Code_____
Telephone: (H)_____ (W)_____ Cell/Pager_____

B. PROHIBITION OF INDIVIDUALS TO SERVE AS SURROGATE

I forbid the following to make health care decisions for me. (Please enter name(s) and relationship to you)
_____
_____

C. WHEN AGENT'S AUTHORITY TAKES EFFECT

My Agent's authority will take effect only if my primary physician determines that I am unable to make my own health care decisions, or if I tell my primary physician that I want my Agent to make decisions for me.

D. **AGENT'S OBLIGATIONS**

1. My Agent shall make decisions for me in accordance with this power of attorney, other instructions I make in this form and my personal wishes, to the extent my Agent knows them. If my wishes on a subject are unknown, the Agent shall make decisions consistent with my best interest, taking into account my personal values to the extent they are known.
2. My Agent shall provide a copy of this advance health care directive to any health care provider or facility that takes on responsibility for my care.

E. **AGENT'S AUTHORITY**

The following are powers normally granted through this document to an Agent for health care decisions. Read this carefully and be sure to cross out any wording you do not want to apply in your case.

1. **Health care**: My Agent is authorized to make the following health care decisions for me:

- Consent or refuse any care, treatment or procedure to maintain, diagnose or otherwise affect my physical or mental condition.
- Select or discharge physicians, other health care providers, or institutions.
- Direct the provision, withholding, or withdrawal of artificial nutrition, hydration, and any other procedure, including cardiopulmonary resuscitation.

2. **Medical records:** My Agent has the same rights as I do to request, receive, examine, copy, and consent to the disclosure or medical, or any other health care information.
3. **Personal care:** My Agent may also make decisions regarding my personal care, including, for instance, determining where I live, providing my meals, hiring household help, providing my transportation, handling my mail and arranging recreation and entertainment for me.

F. **LIMITATIONS ON AGENT'S AUTHORITY**

I understand that under current law, my Agent cannot consent to any of the following on my behalf: commitment or placement in a mental health treatment facility, convulsive treatment, psycho surgery, sterilization, or abortion. In addition, I do not give my Agent permission to do the following:_____

_____

G. **OTHER INSTRUCTIONS TO MY AGENT**

These provisions will not apply unless you initial them on the line before the statement.

_____If I am diagnosed with a terminal illness with no hope of recovery, my Agent shall, at the earliest possible time, arrange for the provision of hospice care.

_____My Agent shall prevent the following individual(s) or representative(s) of the following organization(s) from visiting me during my stay at any residence or health care institution:_____

_____

H. **AGENT'S POST-DEATH AUTHORITY** *(Remember, cross out any wording you do not want to apply you.)*

Following my death, my Agent may do the following:

1. Authorize an autopsy, according to my wishes, or prohibit an autopsy, unless required by law.
2. Direct disposition of my remains, in keeping with any instructions I have made in Part 3 of this form and in keeping with any instructions I have made by will, contract, or other means.
3. Other:_____

_____

PART 2: INSTRUCTIONS FOR HEALTH CARE

This part of the form allows you to give instructions that will be followed by all health care providers and facilities, subject to medically acceptable standards. You do not need to name an Agent for health care decisions in order to make these instructions.

A. **END OF LIFE DECISIONS**

You may choose one of the two statements below by placing your initials on the line before the statement.

_____I want my life prolonged as long as possible within the limits of generally accepted medical standards.
_____I do not want my life to be prolonged if any of the following conditions exist: *(Read these carefully and cross out any you do not want to apply to you.)*

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.
3. The likely risks and burdens of treatment would outweigh the likely benefits.
4. Other situations as described here: _____

B. RELIEF FROM PAIN

If you wish the following to apply for you, place your initials in the line before the statement.

_____I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

C. **OTHER WISHES**

If you wish to write your own further instructions on any subject, you may do so here.

_____

_____

PART 3: DONATION OF ORGANS AT DEATH

This part allows you to donate all or part of your body after your death. Initial one of the following 3 choices.

Upon my death: 1._____ I wish that no organs, tissues or parts be donated.
2._____ I donate any needed organs, tissues or parts.
3._____ I donate only the following:_____

If I initialed 2 or 3 above, my donations may be for the following purpose(s) as indicated by my initials on the line before: _____Any _____Transplant _____Therapy _____Research _____Education

PART 4: PRIMARY PHYSICIAN/OTHERS TO BE CONSULTED REGARDING MY CAPACITY

This part enables you to record the name of your current primary physician who would most likely be called upon to decide whether you are able to make health care decisions yourself. (Please note: If your primary physician changes, it does not invalidate this form.) You may also wish to name other important people in your life whom you would want to be consulted in such a situation.

A. CURRENT PRIMARY CARE PHYSICIAN

Name _____ Address_____
Telephone_____

B. OTHER PEOPLE WHO MAY BE CONSULTED

Name _____ Address _____
Telephone_____
Name _____ Address _____
Telephone_____
Name _____ Address _____
Telephone_____

PART 5: NOMINATION OF CONSERVATOR

This part allows you to nominate someone as conservator for consideration by the court should you become incapacitated and it is necessary for a conservator to be appointed to make decisions for you. You may initial one of the two choices. If you initial number 2, then you must fill in the name(s) of your nominee(s).

If conservatorship proceedings of either my person, my estate, or both are commenced, I nominate the following for consideration by the court to be my conservator.

_____ 1. The person I appointed in Part 1 of this form to be my agent for health care decisions, followed by alternate agents, if any are named.

_____ 2. The person or people named below, in the following order.

Name _____ Address _____

Telephone_____

Name _____ Address _____

Telephone_____

PART 6: SIGNATURE AND WITNESSES

A. SIGNATURE: The person making these instructions must sign and date the form here. If she or he cannot write, another adult may sign instead, in his or her presence, and at his or her direction.

Date: _____ Signature: _____

Address:_____

Printed name: _____Printed name of signer, if different:_____

B. WITNESSES: The advance health directive must be either signed by two witnesses who satisfy the requirements as listed below, or signed in front of a notary public.

STATEMENT OF WITNESS:

I declare under penalty of perjury under the laws of California that:

A. The individual who signed or acknowledged this advance health care directive is personally known to me, or that individual's identity was proven to me by convincing evidence;
B. The individual signed or acknowledged this advance health care directive in my presence;
C. The individual appears to be of sound mind and under no duress, fraud, or undue influence;
D. I am not a person appointed as Agent by this advance health care directive;
E. I am not the individual's health care provider the operator of a community care facility, or the operator of a residential care facility for the elderly, or the employee of any of these facilities.

First witness: **Second witness:**

Date:_____ Signature: _____ Date:_____ Signature: _____

Printed name:_____ Printed name:_____

Address:_____ Address:_____

City, State, Zip Code:_____ City, State, Zip Code:_____

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 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:_____ Signature of Witness:_____

IF YOU ARE A PATIENT IN A SKILLED NURSING FACILITY, YOU MUST READ AND COMPLY WITH THE FOLLOWING DIRECTIONS:

C. STATEMENT OF OMBUDSMAN OR PATIENT ADVOCATE: If you are a patient in a skilled nursing facility, the ombudsman or patient advocate must sign the following statement in addition to signing as one of the witnesses above or in addition to an acknowledgment before a notary public.

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman 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.

Date:_____ Signature:_____

Printed Name:_____

Address:_____

A. **CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC** *(may be used instead of witnesses)*

State of California)

County of _____) **NOTARY SEAL**

On this _____day of _____, 200_, before me, _____,

Notary Public, personally appeared_____,

known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument, the person, or entity upon behalf of which the person acted, executed the instrument.

_____

(Signature of notary public)