

An Advance Health Care Directive is a way to make your health care wishes known in the event you are unable to speak for yourself or prefer someone else to speak for you. An Advance Health Care Directive can serve one or both of these functions:

- **POWER OF ATTORNEY FOR HEALTH CARE (TO APPOINT AN AGENT)**
- **INSTRUCTIONS FOR HEALTH CARE (TO INDICATE YOUR WISHES)**

Persons of all ages may unexpectedly be in a position where they cannot speak for themselves, such as an accident or severe illness. In these situations, having an Advance Health Care Directive assures that your doctor knows your wishes about the kind of care you want and/or who the person is that you want to make decisions on your behalf.

Once you have filled out the form, make sure you discuss your wishes with your family and the person you appoint to speak on your behalf. Also, make copies for those close to you and your doctor, and bring one in to Enloe Medical Center for your medical record.

Advance Health Care Directive forms in English, Spanish and Chinese are available on-line at: <http://www.enloe.org> (Community Health- Advance Directive)

If you have questions, please call Enloe Case Management at 530.332.7502 for more information on an Advance Health Care Directive.

FAQs

Is the Advance Health Care Directive different from a Durable Power of Attorney for Health Care?

The Advance Health Care Directive (AHCD) was enacted by July 2000 legislation and replaced the Durable Power of Attorney for Health Care (DPAHC) and the Natural Death Act Declaration. However, if you had already completed one of these forms that was valid before July 1, 2000, it is still valid now. The only advance directive form that didn't change was the Pre-Hospital Do-Not-Resuscitate form.

Pre-Hospital Do-Not-Resuscitate form? Never heard of it!

This special form allows persons to indicate that they do not want CPR started if something happens to them outside a hospital. Normally, emergency medical personnel are required to start CPR for all persons; having this form protects people from receiving CPR if they choose to forego it. This form must be signed in advance by your doctor.

I've never completed an Advance Health Care Directive before. Why should I?

Persons of all ages may unexpectedly be in a position where they cannot speak for themselves, such as an accident or severe illness. In these situations, having an Advance Health Care Directive assures that your doctor knows your wishes about the kind of care you want and/or who you want to make decisions on your behalf.

Does this mean only one person can decide for me? What if I want others involved, too?

Often many family members are involved in decision-making. Most of the time, that works well, but occasionally, people will disagree about the best course of action. It is usually best to name just one person as the agent (with a back up, if you want). You can also indicate if there is someone who you do not want to make decisions for you.

But I thought the doctors made all those life-and-death decisions anyway?

Actually, doctors tell you about your medical condition, your different treatment options and what may happen with each type of treatment. Though doctors provide guidance, the decision to have, refuse or stop a treatment is yours.

What if something happens to me and no form has been completed?

If you are not able to speak for yourself, the doctor and health care team will turn to one or more family members or friends. The most appropriate decision-maker is the one with a close, caring relationship with you, is aware of your values and beliefs and is willing and able to make the needed decisions.

My “values and beliefs?” But I haven’t talked with anyone about these!

That’s why it is a good idea to talk with family or close friends about the things that are important to you regarding quality of life and how you would want to spend your last days and weeks. Knowing the things that are most important to you will help your loved ones make the best decisions possible on your behalf. If your agent doesn’t know your wishes, then he or she will decide based on what he or she believes is in your best interest.

What if I don’t want to appoint an agent? Or don’t have one to appoint?

You do not have to appoint an agent. You can still complete the Instructions for Health Care portion of the AHCD form, and this will provide your doctors with information to guide your care.

What kinds of things can I write in my Instructions for Health Care?

You can, if you wish, write your preferences about accepting or refusing life-sustaining treatment (such as CPR, feeding tubes or breathing machines), receiving pain medication, making organ donations, indicating your main doctor for providing your care, or other things that express your wishes and values.

If I appoint an agent, what can that person do?

Your agent will make all decisions for you, just like you would if you could. Your agent can choose your doctor and where you will receive your care, speak with your health care team, review your medical record and authorize its release, accept or refuse all medical treatments and make arrangements for you when you die. You should instruct your agent on these matters so he/she knows how to decide for you. The more you tell them the better they will be able to make those decisions on your behalf.

When does my agent make decisions for me?

Usually the agent makes decisions only if you are unable to make them yourself – such as, if you’ve lost the ability to understand things or communicate clearly. However, if you want, your agent can speak on your behalf at any time, even when you are still capable of making your own decisions. You can also appoint a “temporary” agent. For example, if you suddenly become ill, you can tell your doctor if there is someone else you want to make decisions for you. This oral instruction is just as legal as a written one!

Are there other oral instructions that don’t involve a written form?

Yes. You can make an individual health care instruction orally to any person at any time, and it is considered valid. All health care providers must document your wishes in your medical record. But it is often easier to follow your instructions if they are written down.

Can I make up my own form or use one from another state?

Yes. That’s why this law is so flexible. Any type of form is legal as long as it includes 1) your signature and date, 2) the signature of two qualified witnesses, and 3) if you reside in a skilled nursing facility, the signature of the patient advocate or ombudsman. These signatures, however, must include special wording.

Sounds difficult. Do I need an attorney to help with this?

No. Completing an Advance Health Care Directive isn’t difficult, and an attorney is not necessary. But actually the most important part of this is talking to your loved ones. Without that conversation, the best form in the world may not be helpful!

OK, I’ll talk to them! But what should I do with the form after I complete it?

Make copies for all those who are close to you. Take one to your doctor to discuss and ask that it be included in your medical record. Also, take one to your local hospital so if you enter the emergency room it will have your AHCD already in your medical record. Photocopied forms are just as valid as the original. And be sure to keep a copy for yourself in a visible, easy-to-find location – not locked up in a drawer.

What if I change my mind?

You can revoke your form (or your oral instructions) at any time. Also, it’s a good idea to retrieve old forms and replace them with new ones.

Do doctors or hospitals require a patient to have an Advance Health Care Directive form?

No, they cannot require you to complete one. But doctors and hospitals should have information available to you and your family about the form and your right to make health care decisions.

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 1 – POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: _____

Address: _____

Telephone: _____

(home phone)

(work phone)

(cell/pager)

OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: _____

Address: _____

Telephone: _____

(home phone)

(work phone)

(cell/pager)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

Telephone: _____

(home phone)

(work phone)

(cell/pager)

AGENT’S AUTHORITY:

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:

My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

(Initial here)

OR

My agent’s authority to make health care decisions for me takes effect immediately.

(Initial here)

AGENT’S OBLIGATION:

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT’S POSTDEATH AUTHORITY:

My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR:

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

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:

Transplant _____ Research _____
(Initial here) (Initial here)

Therapy _____ Education _____
(Initial here) (Initial here)

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.

Yes _____ No _____
(Initial here) (Initial here)

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

Yes _____ No _____
(Initial here) (Initial here)

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

Yes _____ No _____
(Initial here) (Initial here)

(Health and Safety Code Section 7158.3)

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

Name: _____ Telephone: _____

Address: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

SECOND WITNESS

Name: _____ 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: _____
