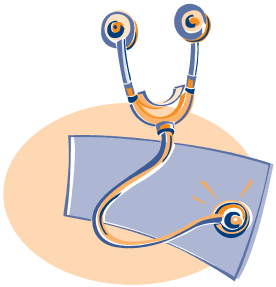
California Advance Health Care Directive

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 medical decision maker.

A medical decision maker is a person who can make health care 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 11 or a notary public on page 12.

Your Name: _____

If you only want to name a medical decision maker 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 11 or a notary public on page 12.

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 medical decision maker and doctor.

What if I have questions about the form?

Ask your doctors, nurses, social workers, friends or family to answer your questions. Lawyers can help too.

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

Write your choices on page 9.

Share this form and your choices with your family, friends, and medical providers.

Part 1 Choose your medical decision maker

The person who can make health care decisions for you if you are too sick to make them yourself

Whom should I choose to be my medical decision maker?

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 decision maker 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 medical decision maker?

If you are too sick to make your own decisions, your doctors will turn to family or friends or a judge to make decisions for you. This person may not know what you want.

The kinds of decisions your medical decision maker can make

She or he will be able to choose:

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- what kind of personal care you get, such as where you live
- who can look at your medical information
- what happens to your body and organs after you die

More decisions your medical decision maker 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 medical decision maker can:

- call in a spiritual leader
- decide if you die at home or in the hospital
- decide where you should be buried or cremated

Write down any decisions you <u>do not</u> want your medical decision maker to make:

_____

_____

Talk to your medical decision maker about this form and your choices.

Your Name: _____

Your Medical Decision Maker

I want this person to make my medical decisions if I cannot make my own

first name last name

( ) – ( ) –

home number work number relationship

street address city state zip code

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

first name last name

( ) – ( ) –

home number work number relationship

street address city state zip code

Put an X next to the sentence you agree with.

- ❑ My medical decision maker can make decisions for me right after I sign this form.
- ❑ My medical decision maker will make decisions for me **only** after I cannot make my own decisions.

How do you want your medical decision maker to follow your healthcare wishes? Put an X next to the one sentence you most agree with.

- ❑ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ❑ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these are some wishes I never want changed:

  _____

  _____

- ❑ **No flexibility:** I want my decision maker to follow my medical wishes exactly, no matter what. It is **not OK** to change my decisions, even if the doctors recommend it.

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

If you are done, you must sign this form 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
- ❍ My life is always worth living no matter how sick I am
- ❍ I am not sure

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 religious or spiritual beliefs?

_____

_____

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

Your Name: _____

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.

Please read this whole page before you make your choice.

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

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** even if I am suffering.
- ❑ 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**. If I am suffering, I want to stop.
- ❑ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a natural death.

- ❑ I want my **medical decision maker** to decide for me.
- ❑ I am not sure.

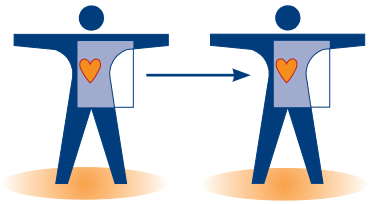
If you want to write down medical wishes that are not on this form, go to page 9.

Your Name: _____

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 **decision maker** 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 **only** want an autopsy if there are questions about my death.
- ❑ I want my **decision maker** to decide.
- ❑ I am not sure.

What should your doctors know about how you want your body to be treated after you die? Do you have funeral or burial wishes?

_____

_____

Your Name: _____

What other wishes are important to you?

Part 3 Sign the form

Before this form can be used, you must:

- sign this form if you are at least 18 years of age
- have two witnesses sign the form or a notary public

Sign your name and write the date.

sign your name / / date

print your first name print your last name

address city state zip code

Part 3 Witnesses

Before this form can be used you must have 2 witnesses sign the form or a notary public

Your witnesses must:

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

Your witnesses cannot:

- be your medical decision maker
- 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

If you do not have witnesses, a notary public must sign on page 12.

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

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 12.

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 this person and he/she could prove who he/she was.
- I am 18 years or older
- I am not his/her medical decision maker
- 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 him/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

_____ / / _____

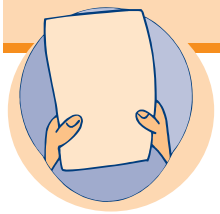
sign your name date

_____

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 family, friends, and medical providers. Talk with them about your medical wishes

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

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

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)

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
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