Advance Health Care Directive

A guide for outlining your health care choices

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Making Your Wishes Known

At Sharp HealthCare, we have been caring for San Diegans for more than 50 years. And while no one likes to think about "what if" when it comes to personal health, drafting a plan for your health care wishes today can be an important tool for you and your loved ones down the road.

Why Create a Plan Now?

Having a plan, called an advance health care directive (or advance directive for short) in place helps ensure you'll get the care you want if you are ever unable to speak for yourself. Think of it as a kind of insurance — something you can do now to protect your quality of life in the future, and to protect those close to you from the emotional burden of having to make difficult health care decisions for you without knowing your wishes.

Who Should Have an Advance Directive?

We recommend that all adults of any age or health status create an advance directive. It can be part of end-of-life planning or created as a precaution in case you're injured or suddenly become ill and are unable to make decisions even for a short time.

Is a Lawyer Needed?

You do not need a lawyer to make a valid advance directive. Just follow the instructions in this booklet and sign in front of two witnesses or a notary public. However, you are always welcome to consult with legal counsel about your document if you'd like.

Can Changes Be Made Later?

It's a good idea to re-evaluate your directive whenever there is a change in personal values, health care agent or life stage, such as college, marriage, divorce, death of a family member or friend, new diagnosis or significant decline in health. You have the right to change or revoke your advance directive at any time.

How to Use This Booklet

This booklet is designed to help you put your health care wishes in writing. We recommend sharing copies of your advance directive with your loved ones, doctor and health care agent(s). Feel free to cross out words and add explanations in the first two parts. Then sign part 3 in the presence of two witnesses **OR** a notary public to complete and legalize this document.

Choosing a Health Care Agent

Use this section to name a trusted individual who can make health care choices for you if you are not able to make your own decisions. If you do not choose a health care agent and do not have decisional capacity, your doctors will ask those closest to you to make health care choices for you.

Who Can Serve as Your Health Care Agent?

A family member or friend who:

- Is 18 or older
- Knows you well
- Is willing to accept this responsibility
- Can be trusted to honor your wishes
- Is able to remain calm while making difficult decisions
- Can communicate effectively with health care providers and family members

Who Cannot Be Your Health Care Agent?

- Your doctor
- Someone who works at the hospital, clinic or facility where you are receiving care, unless he or she is a family member

What Kind of Decisions Can Your Health Care Agent Make?

Unless you limit the authority of your agent in the advance directive, he or she can:

- Decide where you will receive care
- Select or dismiss health care providers
- Accept or reject medications, tests and treatments
- Say what happens to your body and organs after you die
- Take legal action to carry out your wishes

How to Help Your Health Care Agent Speak for You

Ask if the person you've chosen is willing to speak on your behalf to make sure your wishes are honored to the greatest extent possible. If he or she agrees to be your agent, discuss your health care preferences and the reasons for the choices. Be sure to discuss what (if any) quality of life you would find unacceptable and what (if any) aggressive measures you would tolerate.

Be sure to give a copy of your signed directive to your health care agent and your alternate agents.

Name: _____

Date of Birth: _____

Part 1 – A: My Health Care Agent

My agent will speak for me if I am unable to communicate my own health care decisions. He or she will represent my interests to the best of his or her ability, considering what he or she knows about my goals and wishes as well as any preferences I have expressed in this document.

Primary Health Care Agent

Name: _____
First Last

Address: _____
Street City State ZIP

Phone Number: _____
Home Cell Work

Email Address: _____

First Alternate Health Care Agent (Optional)

If my primary agent is not willing, able or reasonably available to make health care decisions for me, I name as my first alternate agent:

Name: _____
First Last

Address: _____
Street City State ZIP

Phone Number: _____
Home Cell Work

Email Address: _____

Second Alternate Health Care Agent (Optional)

If my primary and first alternate agents are not willing, able or reasonably available to make health care decisions for me, I name as my second alternate agent:

Name: _____
First Last

Address: _____
Street City State ZIP

Phone Number: _____
Home Cell Work

Email Address: _____

Part 1 – B: My Health Care Agent's Authority

My agent may begin to represent me when my doctor says I am unable to make my own health care decisions unless I initial the following line:

My agent may immediately begin to make health care decisions for me. _____
Initial here

Limits and/or Special Instructions for My Health Care Agent

In addition to carrying out the wishes expressed in the following pages of this document, my agent also must respect the limits and/or follow the special instructions specified below when making health care decisions for me.

_____

_____

Agent's Authority After My Death

My agent may make decisions for me about organ donation, whether an autopsy is done and what happens to my remains, except as I state here or on page 9 of this form.

_____

_____

Part 1 – C: My Doctor

Primary Care Doctor (Optional)

Name: _____
First Last

Address: _____
Street City State ZIP

Phone Number: _____
Office

Alternate Doctor (Optional)

Name: _____
First Last

Address: _____
Street City State ZIP

Phone Number: _____
Office

Please provide a copy of your advance directive to the doctor(s) named above and discuss your goals and wishes with him/her/them.

Making Your Health Care Choices

Use this section as your "living will" to provide instructions about your specific health care wishes, including life-sustaining treatments for end-of-life care, and any other aspects that are important to you. Before you make your choices, think about what decisions are most likely to achieve your goals for quality of life.

Sometimes life-sustaining treatments are needed only for a short time. For example, a feeding tube may be used to provide nutritional support during a treatment that temporarily prevents you from being able to eat or drink. And equipment such as a respirator or dialysis machine may be used to help manage a chronic health problem.

The choices on the next page refer to end-of-life situations in which you would be unable to survive without mechanical life support.

Discussing the benefits and burdens of these measures with your doctor can help you make informed choices.

Examples of Life-Sustaining Treatments (Life Support)

Cardiopulmonary Resuscitation (CPR) – If your heartbeat and/or breathing stop, CPR can be done to try to revive you. This may involve artificial respiration, forceful pressure on the chest, electric shock to the heart, and/or the use of drugs. There is a risk of breaking ribs and puncturing lungs, and survival may require remaining on mechanical life support.

Artificial Nutrition and Fluids (Feeding Tube) – If you are unable to eat or drink, nutrition and fluids can be given through a tube inserted in your nose or directly into your stomach through a small incision. As with any medical treatment, there is a risk of complications and discomfort. If you prefer not to have a feeding tube, you can be kept comfortable.

Respirator or Ventilator – This is a machine that provides oxygen through a tube if your lungs are not functioning properly. A respirator or ventilator may sustain your life, but if you are gravely ill and your condition is irreversible, it may prolong the dying process.

Dialysis – When the kidneys no longer work properly, this mechanical process can be used to remove waste, salt and excess water from the body. Two small tubes are inserted, one in a vein and the other in an artery, to carry blood into the dialysis machine. The machine filters the blood and places it back into your body. As with a respirator or ventilator, dialysis does not treat most underlying illnesses, and may prolong the dying process.

Part 2 – A: End-of-Life Treatment Decisions

Using the chart below, indicate your preferences with your initials for life-sustaining treatments in certain end-of-life situations. Choose only one box for each situation

	Yes. I would want life-sustaining treatments.	**I'm not sure.** It would depend on the circumstances.	**No.** I would not want life-sustaining treatments.
If I am unconscious, in a coma, or in a vegetative state and there is little to no chance of recovery.			
If I have permanent, severe brain damage (such as severe dementia) that makes me unable to recognize my family or friends.			
If I have a permanent condition where other people must help me with my daily needs, such as eating, bathing or toileting.			
If I need to use a breathing machine and be in bed for the rest of my life.			
If I have pain or other severe symptoms that cause suffering and can't be relieved.			
If I have a condition that will make me die very soon, even with life-sustaining treatments.			
Other:			

Part 2 – B: Comfort and Quality of Life

I want treatment to relieve pain and suffering to be provided as needed. _____
Initial here

If I am NOT expected to recover, I want hospice care to be considered for me at the earliest appropriate time. _____
Initial here

Please describe any exceptions to the statement above, or to the statements you initialed above.

_____

_____

_____

_____

Part 2 – C: Explanation of Wishes

Use this space to explain any of your choices, or add information to help others understand your wishes. This is a good place to mention any cultural/religious views that influence your health care choices or end-of-life planning. Feel free to add pages if you need more space. If you add pages, sign and date each sheet at the time you sign on page 10 in the presence of witnesses or a notary public.

_____

_____

_____

Part 2 – D: Organ and Tissue Donation

Donating your organs and tissues when you die can save lives and improve quality of life for others. Below are some choices for you to consider.

Upon my death: I give the following organs or tissues only.

_____ _____
Initial here

OR

I want to donate any needed organs or tissues. _____
Initial here

OR

I do not want to give any of my organs or tissues, and I do not want anyone who represents me to make a donation on my behalf. _____
Initial here

To learn more about which organs or tissues can be donated, or to register as a donor in the state of California, visit **www.donatelifecalifornia.org**.

If you have chosen to be a donor, please indicate how your gift can be used.

My donation can be used for:

Transplant _____
Initial here

OR **Other Medical Treatments** _____
Initial here

OR **Research** _____
Initial here

OR **Education** _____
Initial here

OR **Wherever Needed** _____
Initial here

Signing the Form

You must sign this form in the presence of two witnesses OR a notary public to make it legal and valid.

Your witnesses must:

- Be over 18
- Validate your identity
- See you sign this form

Your witnesses cannot:

- Be your health care agent
- Be your health care provider
- Work for your health care provider
- Work at the place where you live

One of your witnesses must be someone who is not related to you in any way and does not benefit financially by inheriting money or property after you die.

If you live in a skilled nursing facility, a patient advocate or an ombudsman must sign on page 13 as either one of two witnesses or in addition to notarization.

Your Name: _____
First Last

Signature: _____
Date

Address: _____
Street City State ZIP

Phone Number: _____
Home Cell Work

Email Address: _____

Part 3 – A: Statement of Witnesses

I declare under penalty of perjury under the laws of California 1) that the individual who signed or acknowledged this advance 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 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.

One witness must sign the Additional Witness Statement on page 12.

First Witness

Name: _____
First Last

Signature: _____
Date

Address: _____
Street City State ZIP

Phone Number: _____
Home Cell Work

Second Witness

Name: _____
First Last

Signature: _____
Date

Address: _____
Street City State ZIP

Phone Number: _____
Home Cell Work

Part 3 – B: Additional Witness Statement

At least one of your witnesses must 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.

Witness Signature: _____

Date

ALTERNATIVE TO SIGNING WITH WITNESSES

Part 3 – C: Notary Public

You may use this certificate of acknowledgement before a Notary Public instead of the Statement of Witnesses.

Civil Code Section 1189

State of California, County of _____

On _____ , before me, _____

Date Name and Title of Notary Public

personally appeared _____

Name of Signer

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.

Notary Signature: _____

Notary Seal:

COMPLETE ONLY IF YOU LIVE IN A SKILLED NURSING FACILITY

Part 3 – D: 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.

Name: _____
First Last

Signature: _____
Date

Address: _____
Street City State ZIP

Additional Guidance

If you have questions about creating an advance directive or would like to have a confidential conversation with one of our advance care planning facilitators, call **(619) 517-9798** or email **ACP@sharp.com**.

Sharing This Document

Give a copy of your advance directive to your doctor, health care agent(s) and the hospital where you would go in an emergency. If you wish, extra copies may be shared with others, such as your loved ones, clergy or attorney.

The following individuals have a copy of my advance directive:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Fill out the card attached, tear off, and keep it in your wallet in case of an emergency.

Carry this card in your wallet for reference
in the event of an emergency.

_____

A copy of my advance health care directive may be obtained from:

3. _____ Name _____ Phone _____

2. _____ Name _____ Phone _____

1. _____ Name _____ Phone _____

In an emergency, please consult my health care agent(s):

Cut along the dotted line and fold in half.

Medical Emergency Card

SHARP

I have an advance health care directive.

My name: _____

Signature: _____

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