

# HOSPICE OF SAN JOAQUIN

## Advance Health Care Directives

*This form gives you a way to make your wishes about future health care known to your important people. It is easy-to-understand information that lets you say exactly what you want. In filling out these forms you will have prepared ahead and informed your appointed agent/s of your choices.*

*These guidelines are meant to introduce you and your agent/s to the issues surrounding end-of-life decisions. They are not meant to give you legal advice. Every person is different, and every situation is different. Laws change from time to time. If you have specific questions or there is anything in this form you do not understand, talk to a medical or legal professional for advice.*

### Selecting An Agent

Choose someone who knows you very well. Make certain that your preferences will be respected even if your choices differ from that of your agent/s. A spouse or family member might not be the best choice because they may be too emotionally involved. Choose someone who is willing to accept the responsibility to ensure your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Your Health Care Agent must be at least 18 years or older and can not be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.
- An employee of your health care provider unless your Agent is a relative or is one of your co-workers.

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.

I understand that my Health Care Agent can make health care decisions for me in accordance with this Advance Directive. I want my Agent to be able to do the following:  
*Please cross out anything you don't want your Agent to do that is listed below*

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Agent's understanding of my wishes and values.

- Arrange for admission to a hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve the release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medi-cal or other programs or insurance benefits for me. My Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.

**Designation of Agent**

If I am no longer able to make my own health care decisions, this form names the person/s I choose to make these choices for me. This person/s will be my Health Care Agent.

**Optional: I want my agent’s authority to make health care decisions for me to start now, even though I am still able to make them for myself. I understand and authorize this statement as evidenced by my signature or initials \_\_\_\_\_.**

The Person I Choose As My Health Care Agent Is:

\_\_\_\_\_  
First Choice Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

\_\_\_\_\_  
Second Choice Name

\_\_\_\_\_  
Third Choice Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

Listed below is the kind of medical treatment that I want or don't want in three different situations. I want my Health Care Agent, my family, my doctors and other health care providers, to know these directions.

**If I Am Close To Death:**

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my condition or symptoms.

**If I Am In A Coma And Not Expected To Wake Up Or Recover:**

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my condition or symptoms.

**If I Have Permanent and Severe Brain Damage And I Am Not Expected To Recover:**

If my doctor and another health care professional both decide that I have permanent and severe brain damage (for example, I can open my eyes, but I cannot speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my condition or symptoms.

## **Comforting Treatment**

Circle any that you do want

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to have my favorite music played when possible until my time of death.
- I wish to have personal care like shaving, nail clipping, hair brushing and teeth brushing, as long as they do not cause me pain or discomfort.

## **Comfort Care**

Circle any that you do want

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my church or synagogue told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.
- I wish to have Hospice of San Joaquin services.

**Signing The Advance Health Care Directive**

This Advance Health Care Directive will not be valid unless it is either (1) signed by two qualified adult witnesses who are present when you sign or acknowledge your signature or (2) acknowledged before a notary public in California.

***Make Sure You Sign This Form in the Presence of the Two Witnesses***

I sign my name to and acknowledge this Advance Health Care Directive:

Signature	Date
Address	City/State/Zip
Date of Birth	

**Witness Statement (2 witnesses needed)**

“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.” I also declare that I am at least 18 years of age.

**First Witness**

Name	Telephone
Address	City/State/Zip
Signature of Witness	Date

**Second Witness**

Name	Telephone
Address	City/State/Zip
Signature of Witness	Date



## Directions After Signing Advance Health Care Directive

- Make sure you sign and witness the form just the way it says in the directions. Then your Advance Health Care Directive will be legal and valid.
- Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Directive.
- Keep the original copy you signed in a special place in your home. Do not put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Give your doctor a copy of your Advance Health Care Directive. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them.
- If you are admitted to a hospital or nursing home, take a copy of your Directives with you. Ask that it be put in your medical record.

I have an Advance Health Care Directive	My primary care physician is:
_____	_____
Please consult this document and/or my Agent in an emergency. My Agent is:	Name _____
_____	Address _____ City/State/Zip _____
Name _____	Phone _____
Address _____ City/State/Zip _____	My document is located at: _____
Phone _____	_____

### Cut Out Card, Fold and Laminate for Safekeeping

#### References:

Advance Health Care Directive, California Medical Association, San Francisco, CA  
[www.cmanet.org](http://www.cmanet.org)

Five Wishes, The Robert Wood Johnson Foundation, Princeton, NJ [www.agingwithdignity.org](http://www.agingwithdignity.org)

Talking About Your Choices, [www.partnershipforaging.org](http://www.partnershipforaging.org)

**OPTIONAL**

**I Want My Love Ones to Know The Following:**

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends and others.
- I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (include whichever): buried or cremated.
- My body or remains should be put in the following location\_\_\_\_\_.
- The following person knows my funeral wishes:\_\_\_\_\_.

If anyone asks how I want to be remembered, please say the following about me:

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If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):

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Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die.

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