ADVANCE HEALTH CARE DIRECTIVE STATUS

I have been informed of my right to formulate advance directives concerning health care decisions, and I have been provided with information regarding the execution of an Advance Health Care Directive.

Please check one of the following:

☐ **I have** completed an Advance Health Care Directive and have provided a copy for inclusion in my medical record.

☐ I will provide a copy of my previously executed Advance Health Care Directive to Magan Medical Clinic for inclusion in my medical record.

☐ **I have not** executed an Advance Health Care Directive and I am not interested in further information.

☐ I am interested in formulating an Advance Health Care Directive and will discuss my options with my primary care provider at my next appointment.

Patient Signature: _____ Date: _____

Received By: _____ Date: _____

ADVANCE HEALTH CARE DIRECTIVE INSTRUCTIONS

The Advance Health Care Directive form lets you do one or both of the following things.

1. **You may give instructions about your own health care.**
2. **You also may name someone else to make health care decisions for you.**

It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

Part 1: Power of Attorney

Part 1 lets you:

- **Name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions, or you may have your agent make decisions for you right away, even if you are still able.
- **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 designated **agent** may not be:

- An operator or employee of a community care facility or a residential care facility where you are receiving care.
- Your supervising health care provider (the physician/provider managing your care).
- An employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your designated **agent** may make all health care decisions you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

1. If you *want to limit* the authority of your agent the form includes a place where you can do so.
2. If you *choose not to limit* the authority of your agent, your agent will have the right to:
    - Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition. Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
    - Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
    - Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
    - After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Your agent, by law, may not consent to committing you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes.

You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 3: Donation of Organs *(optional)*

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician *(optional)*

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided. The form must be signed **by two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The witnesses must sign the form on the same date it is signed by the person making the Advance Directive.** See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility*** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time.
You may revoke 1) any part of, or 2) this entire Advance Health Care Directive. If you wish to revoke the appointment of an agent, you must inform your treating health care provider personally or in writing. Completing a new Advance Health Care Directive revokes all previous directives. If you revoke a prior directive, notify the person(s), health care provider(s), hospital, clinic, or care facility that has a copy of your prior directive and give them a copy of your new directive, if you choose to execute one.

We ask that you **complete this form in English** so your caregivers can understand your directions.

ADVANCE HEALTH CARE DIRECTIVE

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

I, _____ | _____, wish to appoint a health care agent.
[Print your full name] [Date of birth]

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Individual you choose as agent:

Name:		Relationship:	
Address:			
Telephone Num:	Home: ( )	Work: ( )	Cell: ( )

ALTERNATE AGENT (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:

Individual you choose as alternate agent:

Name:		Relationship:	
Address:			
Telephone Num:	Home: ( )	Work: ( )	Cell: ( )

SECOND ALTERNATE AGENT (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:

Individual you choose as second alternate agent:

Name:		Relationship:	
Address:			
Telephone Num:	Home: ( )	Work: ( )	Cell: ( )

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) 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, 2) to choose a particular physician or health care facility, and 3) to receive or consent to the release of medical information and records, except as I state here:

(Add additional sheets if needed.)

(1.3) 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 unless I initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately. ____

(1.4) 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 my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH 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.)

(1.6) 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. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) **END-OF-LIFE DECISIONS**: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

A. ☐ Choice **Not To** Prolong Life _____ *(initial here)*
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.
Or
B. ☐ Choice To Prolong Life _____ *(initial here)*
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

(Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

- ☐ I give any needed organs, tissues, or parts
- ☐ I give the following organs, tissues or parts only: _____
- ☐ I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

☐ Transplant ☐ Therapy ☐ Research ☐ Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name:	Telephone:
Address:	

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE:

[Signature of Principal]	[Date of Birth]	[Date of Signing]

(5.3) 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

Print Name: _____ Signature: _____

Address: _____ Date: _____

SECOND WITNESS

Print Name: _____ Signature: _____

Address: _____ Date: _____

(5.4) 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 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 on his or her death under a will now existing or by operation of law.

Signature of Witness: _____ Date: _____

Signature of Witness: _____ Date: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OF 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:

Print Name: _____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California
County of _____ } ss

On this *(date)* _____ , before me *(Name and Title of Officer)*, _____

Notary Public in and for said State, personally appeared *(Name of Signer)* _____ personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed it.

WITNESS my hand and official seal.

Signature: _____ **Notary Seal**