MY HEALTH CARE CHOICES (OPTIONAL SUPPLEMENT)

Personal Health Care Instructions Communication Form

Name: ______________________________ Kaiser MRN#: __________________

I. How much I want to know about my condition:

(Please mark statement 1 or 2.)

- ❑ 1: I wish to know all relevant facts about my condition. I can cope better with what I know than with the unknown.
- ❑ 2: I do not wish to know all the details of my condition, especially if the news is bad. I fear that such knowledge will lessen my will to live and will cast a shadow over the time left to me. If there is bad news about my condition, I want my health care agent to take over making medical decisions for me, even if I still have mental capacity to make health care decisions myself.

II. How strictly I want my agent to follow my instructions:

- ❑ A. ___ I am writing how I want health care decisions made. **I want my agent to strictly follow this document.** If other decisions come up that I have not made here, I want my agent to rely on other information he or she has about my wishes and my values.
- ❑ B. ___ I am trying to guide my agent in how I want health care decisions made, but I realize that I cannot think of everything that might happen. **I want my agent to have ultimate authority to make decisions concerning my health care for me if I cannot do so for myself.** I trust my agent to draw on all sources of knowledge about my wishes and values.

Additional comments to guide your agent in making decisions on your behalf (add additional sheets if you need them):

III. If I am dying, it is important for me to be:

- ❑ at home.
- ❑ in the hospital.

Additional Instructions:

Initials: ________

IV. Near the end of life, when would you want your doctors to allow your death to take its natural course? For example, which of these sentences do you most agree with: 1 or 2?

❑ 1: My life is only worth living if I can:
(Check all that apply; add more if you want.)
- ❑ talk to family or friends
- ❑ communicate in some way with my loved ones
- ❑ recover enough to feed, bathe, or take care of myself
- ❑ be free from pain
- ❑ live without being hooked up to machines
- ❑ not be a burden to my family or others
- ❑ make decisions for myself
- ❑ be faithful to my beliefs
- ❑ I am not sure

❑ 2: My life is always worth living no matter how sick I am, even if I am unable to communicate at all and even if I won't get better.

V. If I have a serious chronic illness or I am so sick that I may die soon:

(Choose the option you agree with most.)

❑ Any treatments can be tried to see if they will help. Even if treatments **do not work** and there is little hope of getting better, **I want to stay** on life support machines until I die.

❑ Any treatments can be tried to see if they will 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.

Initials: ________

V. cont'd. Check all that apply:

❑ I have already decided that I do **not** want to have the following treatments, even if it means that I might die by not having them:

- ❑ I want **no** attempts at CPR.
- ❑ I want **no** breathing machine.
- ❑ I want **no** dialysis.
- ❑ I want **no** blood transfusion.
- ❑ I want **no** artificial feeding and hydration.
- ❑ I want **no** medicines of any kind.
- ❑ ____
- ❑ **I do not want *any* life support** treatments at all, even if it means that I might die by not having them.
- ❑ **I do not want to stay life support** machines longer than____________ (fill in time span) and would want to _______________.

VI. Religion or spirituality is

❑ important to me

❑ unimportant to me

What my doctors should know about my religion or spirituality:

VII. After my death

❑ I **want** to donate my organs. *Which organs do you want to donate?*

- ❑ any organs
- ❑ only the following organs ____

❑ I **do not** want to donate my organs.

❑ I want my **health care agent** to decide.

VIII. What my agent and doctors should know about how I want my body to be treated after I die:

❑ I **do not** want an autopsy.

❑ I **want** an autopsy if there are questions about my death.

❑ I want my **health care agent** to decide about authorizing an autopsy.

❑ My preferences about funeral/burial/cremation are______________________________
____
____.

❑ I want my **health care agent** to decide about burial or cremation.

Additional instructions:

Signature: ____________________________________ Date: _________________

If you are completing this form at the same time as your Advance Health Care Directive, please remember to attach it to the AHCD so your signature can also be witnessed or verified by a notary public.

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

Including Power of Attorney for Health Care

IMPRINT / MRN

PART 1: APPOINTING AN AGENT TO MAKE HEALTH CARE DECISIONS

Note: You should discuss your wishes in detail with your designated agent(s).

1 A

My name is: ______________________________ Date of birth: ____________________

My address is: ____

In this document I appoint an agent. I want this person to help make my medical decisions.

Your agent or alternate agent **cannot** be:

- Your primary physician
- Someone who works where you receive care (unless you are related to that person or you are co-workers).

1 B

- PRIMARY AGENT:

  Agent's Name: ____

  Address: ____

  Phone: ____

  (Indicate home, work, pager, and cellular phone.)

- 1st ALTERNATE AGENT (If agent is not willing, able, or reasonably available to serve.)

  Name of first alternate agent: _____________________________

  Address: ____

  Phone: ____

  (Indicate home, work, pager, and cellular phone)

- 2nd ALTERNATE AGENT (If agent and 1st alternate are unavailable or unwilling to serve.)

  Name of second alternate agent: ___________________________

  Address: ____

  Phone: ____

  (Indicate home, work, pager, and cellular phone)

WHEN WILL MY AGENT MAKE DECISIONS?:

(Put an X next to the sentence you agree with.)

1 C

❑ My health care agent can make health care decisions for me while I still have mental capacity to make decisions. ______ {initial here}

❑ My health care agent will make health care decisions for me ONLY when I do not have the mental capacity to make my own health care decisions. ______ {initial here}

Name: ______________________________ MRN#:____________________

WHAT MY AGENT MAY DO

My agent will be allowed to make health care decisions for me just as I can presently make my own. For example, my agent may (1) accept or refuse treatment for me, including accepting or discontinuing artificial nutrition and fluid that is given through a tube into my stomach or into a vein. (2) Choose for me a particular physician or health care facility. (3) Receive or review my medical information and records, or permit release of my records for others' review. _______ {initial here}

1 D

WHO MAY ***NOT*** MAKE MY MEDICAL DECISIONS

❑ No Exclusions _______ {initial here}

1 E

or ❑ The following individual(s) are to be EXCLUDED from any part of health care decision-making for me:

____ _______ {initial here}

AFTER MY DEATH

My agent will be able to authorize an autopsy. My agent will be able to donate all or part of my body. My agent will be able to decide what to do with my body. If I have written a will or made arrangements for what happens to my body after my death, my agent should follow those instructions.

❑ No Exceptions _______ {initial here}

1 F

or ❑ I want to make exceptions to this authority. I write them here:

____

____ {initial here}

or ❑ I want to make exceptions to this authority. See the attachment to this form.

(Sign and date the attached pages when this document is witnessed.)

PART 2: HEALTH CARE INSTRUCTIONS (Cross out the sections that do not apply)

❑ I have made additional written instructions for my agent and attached them.

(Sign and date the attached pages when this document is witnessed.)

2 A

PERSONAL CARE DECISIONS: I want my agent(s) to decide about personal care on my behalf. For example, I want my agent to be able to decide where I will live, choose my clothing, receive my mail, care for my personal belongings and care for my pet(s) if any. My agent may make all other decisions of a personal nature not included in the description of health care. _____ {initial here}

2 B

REVOCATION OF PREVIOUS DOCUMENTS: I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death Act Declaration. I have the right to revoke this directive later by creating a new one.

_____ {initial here}

Name: ______________________________ MRN#:____________________

PART 3: SIGNATURE OF PERSON WHO IS MAKING THIS DIRECTIVE

Sign the document in the presence of the witnesses or the Notary.

3

Date: _______________ Signature: ____

If the person making this directive is unable to write, have the person make a mark. Have a witness write the name of the person making this directive and sign the next page.

PART 4: THIS DOCUMENT MUST EITHER BE SIGNED BY TWO WITNESSES OR NOTARIZED ON THE NEXT PAGE.

WITNESSES: Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements:

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.

ONLY ONE WITNESS CAN BE A FAMILY MEMBER.

4 A

First Witness: ______________________________ ______________________________

Name (printed) Signature

Date: _________________ Address: ____

Second Witness: ______________________________ ______________________________

Name (printed) Signature

Date: _________________ Address: ____

ONE WITNESS MUST BE SOMEONE OTHER THAN FAMILY and must not benefit financially (get any money or be named in your will) after you die. Have that person sign again below:

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA

(1) That I am not related to the individual executing this Advance Health Care Directive by blood, marriage, or adoption,

(2) 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.

4 B

Date: _________________ Signature: ____

Name: ______________________________ MRN#:______________________

ONLY if the person making this directive is unable to write, witnesses complete this section:

______________________________, being unable to write, made his/her mark in our presence and requested the first of the undersigned to write his/her name, which he/she did, and we now subscribe our names as witnesses thereto.

______________________________	______________________________
Signature of Witness #1	Signature of Witness #2

CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT OF NOTARY PUBLIC

(Not required if two-witness method is followed)

State of California, County of ______________________

On __________________ before me, ____
Date Name and Title of Officer

Personally appeared ____
Names(s) of Signer(s)

who provided 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 authorized signature(s) on the instrument 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 ______________________________

(seal)

If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a representative of California's Long-Term Care Ombudsman Program. If the two-witness method is chosen, the Ombudsman Program representative may serve as one of the two witnesses, or may serve as a third witness.
If the notarization method is chosen, the Ombudsman Program representative serves as a separate witness.

❏ I do not currently reside in a skilled nursing facility. ______ {initial here}

4 C

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE

(Required ONLY if person appointing the agent currently resides in a nursing facility.)

I declare under penalty of perjury under the laws of California that I am an ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

______________________	______________________	____________
Name (printed)	Signature	Date