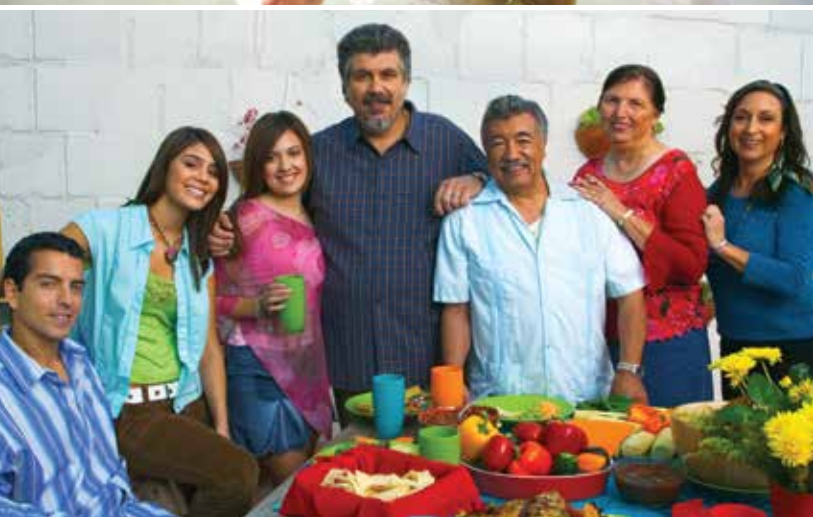
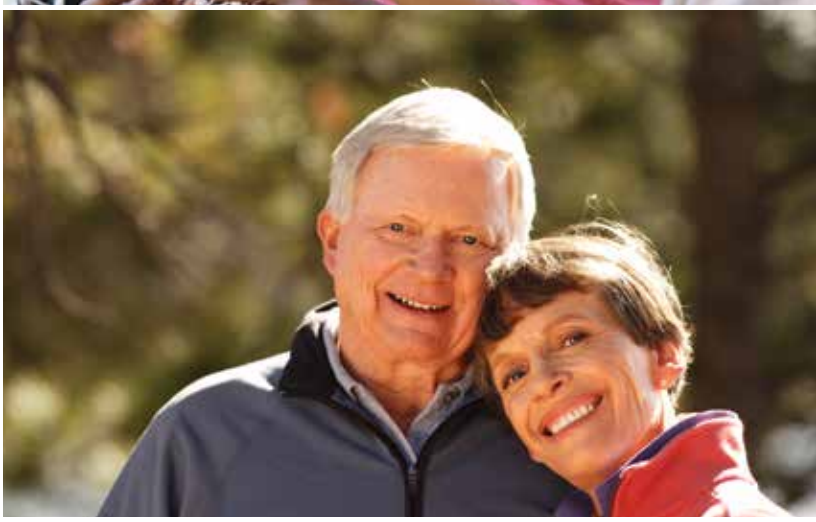
# Advance Health Care Directive





## LIFE CARE **planning**

my values, my choices, my care

**kp.org/lifecareplan**

**REMEMBER**

1. Have this document witnessed or notarized
2. Sign and date
3. Return a copy to Kaiser Permanente

KAISER PERMANENTE®

Full name: _____
Medical Record #: _____

## Introduction

This Advance Health Care Directive allows you to share your values, your choices, and your instructions about your health care. This form may be used to:

- Name someone you trust to make health care decisions for you (your "health care agent"), OR
- Provide written instructions about your health care, OR
- Both name a health care agent AND provide written instructions for health care.

**Part 1** allows you to name a health care agent.

**Part 2** gives you an opportunity to share your values and what is important to you.

**Part 3** allows you to give written instructions about your health care.

**Part 4** allows you to guide your agent's decision making by stating your hopes and wishes.

**Part 5** allows you to make your Advance Health Care Directive legally valid in the State of California.

**Part 6** prepares you to share your wishes and this document with others.

You are free to complete or modify all or any part of this form, or use a different form.

This Advance Health Care Directive will replace any Advance Health Care Directive you have completed in the past, to the extent that they differ. If you want to cancel or change your named agent, complete a new document or inform your health care provider in person.

Full name: _____

Medical Record number: _____ Date of birth: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____



| Document type: Advance Directive | Description: Advance Directive Signed On |
|---|---|

Full name: _____
Medical Record #: _____

## Part 1. My Health Care Agent

*Selecting a health care agent:*
*Choose someone who knows you well, who you trust to honor your views and values, and who is able to make difficult decisions in stressful situations. Once you have selected your health care agent, take the time to discuss your views and treatment goals with that person and make sure they are willing to act as your decision maker.*

If I am unable to communicate my wishes and health care decisions, or if my health care provider has determined that I am not able to make my own health care decisions, I choose the following person(s) to make my health care decisions.*

My health care agent must make health care decisions that are consistent with my instructions in this document, if any, and other wishes known by my agent. Otherwise, my agent must make health care decisions that he or she believes to be in my best interest, considering what he or she knows about my personal values.

This form does not give my health care agent the authority to make financial or other business decisions. My health care agent does not have the power to place me in a mental health treatment facility or consent to some types of mental health treatments.

### My primary (main) health care agent is:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

*I understand that my health care agent cannot be my supervising health care provider or an operator of a community or residential care facility where I am receiving care. My agent also may not be an employee of a community care, residential care, or health care facility where I am receiving care, unless that person is my relative by blood, marriage, or adoption, is my registered domestic partner, or is my co-worker.

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Full name: _____
Medical Record #: _____

If I cancel my primary health care agent's authority, or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name the individual below as my first alternate agent.

### First alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

If I cancel my agent's authority, primary or first alternate, or if neither is willing, able, or reasonably available to make a health care decision for me, I name the individual below as my second alternate agent.

### Second alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

### Powers of my health care agent:

**Unless I limit my agent's authority, my health care agent has all of the following powers:**

A. Make choices for me about my health care. This includes decisions about tests, medicine, and surgery. It also includes decisions to provide, not provide, or stop all forms of health care to keep me alive, including artificial nutrition (food), hydration (water), and cardiopulmonary resuscitation.

B. Decide which physicians, health providers, and organizations provide my medical treatment.

C. Arrange for and make decisions about the care of my body after death (including autopsy and organ donation).

Full name: _____
Medical Record #: _____

*Please provide any additional comments or restrictions to your agent's authority here. (For example, you may name people you would not want involved in medical decisions on your behalf. You may also specify decisions you would not want your agent to make.) Attach additional page(s) if necessary.*

**Additional health care agent instructions:**

*Check the box or boxes below, if you want your agent to follow these instructions.*

❑ I want my agent to continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership has been completed.

❑ I want my agent to immediately begin making health care decisions for me even if I am able to decide or speak for myself.

Need additional assistance?
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Full name: _____
Medical Record #: _____

## Part 2. My Values and Beliefs

I want my agent and loved ones to know what matters most to me, so that they can make decisions about my health care that match who I am and what is important to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, who I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

**1. If I were having a good day, I would be doing the following:**

**2. What matters most to me is:**

**3. Life would no longer be worth living if I were not able to:**

**4. Religious or spiritual traditions:**

I am of the _____ faith, and am a member of (faith/spiritual community) _____ in (city) _____, (phone #) _____. I would like my agent to notify them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

❑ I have no specific religious or spiritual traditions.

Full name: _____
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## Part 3. My Health Care Instructions

*If you choose not to provide written instructions, your health care agent will make decisions based on your spoken directions. If your directions are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.*

*In the situation below, we ask you to consider a sudden unexpected event that leaves you unable to communicate for yourself.*

I ask that my health care agent represent my choices as detailed below, and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are unable to make decisions on my behalf, this document represents my wishes.

### 1. Treatments to prolong life

**Consider the following situation:**

You have a sudden accident or stroke.

Doctors have determined you have a brain injury, leaving you unable to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine), or a feeding tube, are required to keep you alive. In this situation what would you want?

**I would want to be kept comfortable and:**

**Choose One**

- ❑ I would want to STOP life-sustaining treatment. I realize this would probably lead me to die sooner than if I were to continue treatment.
- ❑ I would want to continue life-sustaining treatments.

*Please provide any additional instructions about life-sustaining treatments. For example, you may want to state a specific time period that you would want to be kept alive if there were no improvement to your health.*

Full name: _____
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## 2. CPR (Cardiopulmonary resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* If you would like additional information about CPR, please request the brochure called **CPR: Cardiopulmonary Resuscitation**

If you do not want CPR, please discuss with your physician other documents you may want to complete.

**In the event that your heart and breathing stop, what would you want?**

**Choose One**

- ❑ I always want CPR attempted.
- ❑ I never want CPR attempted, but rather want to permit a natural death.
- ❑ I want CPR attempted unless the doctor treating me determines any of the following:
  - I have an incurable illness or injury and am dying; or
  - I have no reasonable chance of survival if my heart or breathing stops; or
  - I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause significant suffering.

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*Research shows that if you are in a hospital and get CPR, you have a 22 percent chance of surviving and leaving the hospital alive. Saket Girotra, M.D., Brahmajee K. Nallamothu, M.D., M.P.H., John A. Spertus, M.D., M.P.H., et al. "Trends in Survival after In-Hospital Cardiac Arrest;" *New England Journal of Medicine* 367; 20 November 15, 2012.



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## Part 4. My Hopes and Wishes (Optional)

1. **As I'm nearing my death, I want my loved ones to know I would appreciate having the following (prayers, rituals, music) and where I prefer to die:**

2. **Other wishes/instructions**:

3. **Organ donation** (If you have no preference, your agent may decide for you.):

   ❑ **Upon my death, I want to donate my eyes, tissues, and any organs. My specific wishes (if any) are:**

   ❑ **Upon my death, I only wish to donate the following organs, tissues, or body parts:**

   ❑ **I DO NOT want to donate my eyes, tissues, and/or organs.**

Full name: _____
Medical Record #: _____

## Part 4. My Hopes and Wishes (Optional)

**4 . If you wish to donate your body for research, arrangements must be made in advance:**
**Organization/Institution Name:** _____ **Phone:** _____

Full name: _____
Medical Record #: _____

## Part 5. Making This Document Legally Valid

*To make your Advance Health Care Directive legally valid in California, it must be signed by two witnesses, OR acknowledged before a Notary Public. Follow the steps outlined below in the order in which they are listed:*

**1. Choose EITHER**

**Two Witnesses** **OR** **Notary Public**

- One of your witnesses cannot be related to you (by blood, marriage, or adoption) and cannot be entitled to any part of your estate.
- Your primary and alternate agents cannot sign as witnesses.
- When you are with your witnesses, sign or acknowledge your signature.
- Witnesses will sign on page 11.
- You will sign on page 12.

- Do NOT sign this document unless you are with a Notary Public.
- Notary Public will sign on page 12. (Skip page 11.)
- You will sign on page 12.

### 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 an ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Signature: _____ Date: _____

Full name: _____
Medical Record #: _____

***This form must be signed by two witnesses (only one of whom can be related to you), OR acknowledged before a Notary Public. If using a Notary Public, skip this page.***

## 1 Statement of Witnesses

**STATEMENT OF WITNESSES:** I declare under penalty of perjury under the laws of California

- 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,
- that the individual signed or acknowledged this Advance Health Care Directive in my presence,
- that the individual appears to be of sound mind and under no duress, fraud, or undue influence,
- that I am not appointed as an agent by this Advance Health Care Directive, and
- 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, or an employee of an operator of a residential care facility for the elderly.

### Witness Number One:

Print full name: _____

Address: _____

Signature: _____ Date: _____

### Witness Number Two:

Print full name: _____

Address: _____

Signature: _____ Date: _____

**ADDITIONAL STATEMENT OF WITNESS:** At least one of the witnesses must meet the following requirements and sign the following declaration:

1 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.

Print full name: _____ Signature: _____

Date: _____



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## 2 SIGNATURE

My name printed: _____

**My Signature:** _____ **Date:** _____

If you are physically unable to sign, any mark you make that you intend to be your signature is acceptable.

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.

## 1 Notary Public

State of California

County of _____

on _____ before me, _____,
Date — Name and Title of Officer

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.

Signature _____ (Seal)

Full name: _____
Medical Record #: _____

## Part 6. Next Steps

*Now that you have completed your Advance Health Care Directive, you should also take the following steps.*

### Discuss:

- ❑ Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to perform this important job for you in the future.
- ❑ Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.

### Give copies:

- ❑ Give your health care agent a copy of your Advance Health Care Directive.
- ❑ Bring a copy of your Advance Health Care Directive to your next scheduled appointment

  **- OR -**

  Send in your copy by mail to:
  Kaiser Permanente Central Scanning, 1011 S. East Street, Anaheim, CA 92805

  **- OR -**

  Via email: SCALCentralized-Scanning-Center@kp.org
- ❑ Make a copy for yourself and keep it where it can be easily found.

### Take with you:

- ❑ If you go to a hospital or nursing home, take a copy of your Advance Health Care Directive and ask that it be placed in your medical record.
- ❑ Take a copy with you any time you will be away from home for an extended period of time.

### Review regularly:

- ❑ Review your health care wishes whenever any of the "Five D's" occur:

  **Decade—**when you start each new decade of your life.

  **Death—**whenever you experience the death of a loved one.

  **Divorce—**when you experience a divorce or other major family change.

  **Diagnosis—**when you are diagnosed with a serious health condition.

  **Decline—**when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

### Changing your Advance Health Care Directive:

If your wishes or health care agent change, please notify your provider or fill out a new Advance Health Care Directive. Tell your agent, your family, and anyone else who has a copy, and provide a copy to Kaiser Permanente.

| Document type: Advance Directive | Description: Advance Directive Signed On |
|---|---|

Full name: _____
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**Copies of this document have been given to:**

- Primary (Main) Health Care Agent

  Full name: _____

  Telephone: _____

- Alternate Health Care Agent #1

  Full name: _____

  Telephone: _____

- Alternate Health Care Agent #2

  Full name: _____

  Telephone: _____

- Health Care Provider/Clinic

  Name: _____

  Telephone: _____

- Others:

  Name: _____

  Telephone: _____

3 Bring a copy of your Advance Health Care Directive to your next scheduled appointment

**- OR -**

Send in your copy by mail to: Kaiser Permanente Central Scanning
1011 S. East Street
Anaheim, CA 92805

**- OR -**

Via email: SCALCentralized-Scanning-Center@kp.org

**Need additional assistance?**
**kp.org/lifecareplan**

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Center for Healthy Living
CHL032e (5/20)
**kp.org**