醫護事宜預立醫囑 (Advance Health Care Directive, AHCD)
(Advance Health Care Directive (AHCD))

CALIFORNIA
(CALIFORNIA)

我的名字：_____
(My first name:)
我的姓氏：_____
(My last name:)
我的出生日期：_____/_____/_____
(My date of birth:)
我的醫療記錄號碼：_____
(My medical record number:)

KP use: patient label

本文件有兩個版本。此版本為精簡版。您可以前往**kp.org/lifecareplan**查看兩種版本或向您的醫生索取。選擇符合您需求的版本。
(There are two versions of this document. This is the shorter one. You can view the two versions on **kp.org/lifecareplan** or ask your doctor for them. Choose the one you prefer.)

第1步 (Step 1)

選擇醫護事宜代理人（需具有決定權）。如有需要，您也可以選擇一名替代代理人。
(Choose a health care agent (decision maker). You can also choose an alternate agent if you want one.)

此人必須：
(This person is:)

- 年滿18歲或以上，並且非常瞭解您的價值觀和信念；
  (18 or older and knows your values and beliefs well;)
- 願意並能夠為您處理此事；
  (willing and able to do this for you;)
- 願意尊重**您的**偏好選擇，即使與他們自身的偏好選擇有所不同；
  (willing to honor **your** preferences even if they are different from their own;)
- 不是您的醫生或其他照顧您的保健專業人員。
  (not your doctor or another health care professional who is caring for you.)

我選擇_____ 關係：_____
(I choose) (relationship:)
電話號碼：_____ 電子郵件：_____,
(phone number:) (email:)
作為我的醫護事宜代理人，在我無法自己做出醫護事宜決定的情況下，可以為我做出醫護事宜相關決定。
(as my health care agent to make health care decisions for me if I'm not able to make them for myself.)
我選擇_____ 關係：_____
(I choose) (relationship:)
電話號碼：_____ 電子郵件：_____,
(phone number:) (email:)
在我的主要醫護事宜代理人不願意、沒有能力或無法合理地為我做出醫護事宜相關決定的情況下，作為我的替代醫護事宜代理人。
(as my alternate health care agent if my primary health care agent is not willing, able, or reasonably available to make health care decisions for me.)

第2步 (Step 2)

為我的醫護事宜代理人和醫護團隊提供指導。從下方方塊框中，**擇一**選取：
(Give guidance to my health care agent and care team. Choose **ONE** box only:)

如果我得了無法治癒的疾病，並且會在短時間內導致死亡，
(If I have an illness that is not curable and will result in my death in a short time,)
或我已失去意識，我的多位醫生認為我不會再好轉，
(OR I become unconscious, and my doctors do not think I will improve,)
或治療可能的風險和負擔，將超過預估的好處……
(OR the likely risks and burdens of treatment would outweigh the expected benefits...)

☐ 我希望在普遍接受的健康護理標準範圍內盡可能長時間地活著。
(I want to be kept alive as long as possible within the limits of generally accepted health care standards.)
☐ 我不希望延長我的生命。我將會停止維持生命跡象的相關治療，或不開始治療。
(I do not want my life to be prolonged. I would stop treatments to keep me alive or not start them.)
☐ 我不確定我最同意哪種敘述。我相信我的醫護事宜代理人會做對我最有利的決定。
(I am not sure which statements I most agree with. I trust my health care agent to do what is best for me.)

您是否還有其他關於您或您的醫護偏好選擇，需要告知您的醫護團隊？
(Is there anything else your care team should know about you or your medical preferences?)

_____
_____
_____

第3步 (Step 3)

在下方簽署表格。請「兩名」見證人（選項1）或一名Notary Public（選項2）簽署。
(Sign the form below. Ask either TWO witnesses (Option 1) OR a notary public (Option 2) to also sign.)

我的姓名（請用正楷填寫）：_____
(My name (please print:))
我的簽名：_____ 日期：_____
(My signature) (Date)

KAISER PERMANENTE®

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選項1 (Option 1)

我選擇「兩名見證人」。
(I choose TWO WITNESSES.)

所有見證人必須閱讀並接受所有以下要求。
(ALL WITNESSES MUST READ AND ACCEPT ALL THESE REQUIREMENTS)

- 根據California法律，我聲明：
  (I declare under penalty of perjury under the laws of California that:)
- 我已年滿18歲；
  (I am at least 18 years old;)
- 我不是被本醫護事宜預立醫囑任命的代理人；
  (I am not a person appointed as agent by this Advance Health Care Directive;)
- 只有一名見證人可以是親屬；
  (only one of the witnesses can be family related;)
- 我認識簽署或承認本醫護事宜預先授權書的人士，或有可信證據向我證明此人身分；
  (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;)
- 此人是在我在場的情況下簽署或承認本醫護事宜預立醫囑；
  (the individual signed or acknowledged this Advance Health Care Directive in my presence;)
- 此人看起來精神健全，沒有受到脅迫、詐欺或不當影響；
  (the individual appears to be of sound mind and under no duress, fraud, or undue influence;)
- 我不是此人的醫療保健提供者、此人醫療保健提供者的僱員、社區護理機構的運營者、社區護理機構運營者的僱員、居家養老機構的運營者，也不是居家養老機構運營者的僱員
  (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)

一號見證人：
(WITNESS NUMBER ONE:)
正楷姓名：_____ 簽名：_____
(Print name:) (Signature:)
地址：_____ 日期：_____
(Address:) (Date:)

二號見證人：
(WITNESS NUMBER TWO:)
正楷姓名：_____ 簽名：_____
(Print name:) (Signature:)
地址：_____ 日期：_____
(Address:) (Date:)

見證人補充陳述：上述見證人中至少一名必須同時簽署以下聲明：在願意接受California法律偽證罪之懲罰下，我進一步聲明我與簽署本醫護事宜預立醫囑的個人沒有血緣、婚姻或收養關係，且據我所知，根據現有遺囑或法律規範，我無權獲得此人死亡後的任何部分遺產。
(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 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 their death under a will now existing or by operation of law.)
正楷姓名：_____ 簽名：_____
(Print Name:) (Signature:)

僅適用於California專業護理機構居民
只有當您住在護理院的情況下，才將此表格交給您的護理院主管。California法律要求護理院居民須請護理院的監察員作為醫護事宜預立醫囑 (AHCD) 的額外見證人。

(FOR CALIFORNIA SKILLED NURSING FACILITY RESIDENTS ONLY)
(STATEMENT OF THE 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.")
監察員簽名：_____ 日期：_____
(Signature of ombudsman:) (Date:)
正楷姓名：_____
(Print name:)

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選項2 (Option 2)

我選擇一名Notary Public而不是兩名見證人。
(I choose a NOTARY PUBLIC instead of two witnesses.)

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.

State of California, County of: _____

On _____ before me, _____ personally appeared _____ 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 that 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 of Notary Public) (Seal)

後續步驟

- ☐ **正本由您保留。**
- ☐ **將副本交給您的醫護事宜代理人。**
- ☐ **在下次預約前往Kaiser Permanente時攜帶一份副本，或者**
- ☐ **透過郵寄方式將副本寄至：**Kaiser Permanente Central Scanning, 1011 S. East Street, Anaheim, CA 92805，**或寄電子郵件至：**SCALCentralized-Scanning-Center@kp.org
- ☐ **與您的醫護事宜代理人**討論您的價值觀、信念和醫護偏好選擇。使用您的AHCD引導對話，並確保他們能夠肩負起此一角色。**請務必讓您的親人、家人和好友**知道您選擇了何人作為您的醫護事宜代理人、您的醫護偏好選擇是什麼，以及原因為何。
- ☐ **隨身攜帶您的**AHCD。當您去醫院或護理院時，請隨身攜帶一份您的AHCD副本，並要求記錄在您的醫療記錄中。

您可以隨時取消或變更AHCD中的任何選擇。隨著您的生活或健康狀況發生變化，您可以填寫新的文件或親自告知您的醫生想變更代理人和偏好選擇。

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