INSTRUCTION WORKSHEET *(add or delete as desired)*

"Comfort Care Only" means providing relief of pain and suffering in all cases, but not providing machines, devices, or medications that prolong my life—in other words, letting "Nature take its course".

"Life Support" means the use of any machines, devices, or medications that are needed to keep me alive. They may include, but are not limited to, respirator/ventilator, tube feeding, dialysis, CPR, pacemaker, antibiotics, and transfusions.

If life support has been initiated, as in an emergency, my agent has the power to have it stopped if he/she believes I would not have wanted the intervention(s).

As long as I can make my wishes known, my doctors will
talk to me and I will make my own health care decisions,
but:

If I can no longer make my own decisions for my care, *and I am never expected to be able to make those decisions,* **and I am unable to recognize and communicate meaningfully with my family and/or friends,** would I want

"Comfort Care Only" _____ ***or*** would I want "Life Support" _____

If I can no longer make my own decisions for my care*, and I am never expected to be able to make those decisions,* **and I am unable to live independently and must live in a skilled nursing facility,** would I want

"Comfort Care Only" _____ ***or*** would I want "Life Support" _____

If I can no longer make my own decisions for my care, *and I am never expected to be able to make those decisions,* **and I will be bedridden for the rest of my life,** would I want "Comfort Care Only" _____ ***or*** would I want "Life Support" _____

If I can no longer make my own decisions for my care*, and I am never expected to be able to make those decisions,* **and I am unable to care for myself (dressing, bathing, toileting, etc.)** would I want

"Comfort Care Only" _____ ***or*** would I want "Life Support" _____

If I can no longer make my own decisions for my care, *and I am never expected to be able to make those decisions,* **and I cannot eat by mouth and must be given food and water through tubes of some sort,** would I want

"Comfort Care Only" _____ ***or*** would I want "Life Support" _____

If I can no longer make my own decisions for my care, *and I am never expected to be able to make those decisions,* **would I like to have treatment for alleviation of pain and suffering to be provided at all times, even if it hastens my death?**

☐ yes ☐ no

(signature)_____ (date)_____

This page must be signed and dated the same day as the
Advance Health Care Directive if it is to have the same force of law as that document.

SPECIFIC ISSUES WORKSHEET *(add or delete as desired)*

1) **If** I am unable to give informed consent to health care decisions—and assuming therefore that I am unable to make other important life decisions as well,

and

2) **If** the best available medical opinion is that there is little or no likelihood that my illness or condition will ever improve to the point where I will be able to give informed consent to health care decisions,

then:

I not only request but demand that the following instructions for my care be followed by my family, friends, physicians, other care-givers, and health care institutions:

1. Food and fluids: food and fluids may be offered, but not forced on me, as long as I am conscious to take them by mouth. I must show volition, not just passively accept what is offered. Do not try to coax or cajole me into eating if I resist in any manner.

If I am unable to swallow safely, I do not wish to have my life prolonged by the administration of food or fluids by any artificial means, neither by needle nor by tubes through mouth, nose, stomach or intestines. I wish appropriate medication for any discomfort caused as a result. It is my wish to die if nutrition cannot be provided in the normal manner.

2. Infection: the only treatment I will accept for infection is for pain management. Infection likely to prove fatal should be left to run its course without treatment except for pain. I recognize and agree with the old saying, "pneumonia is the Old Man's friend."

3. Medical intensive care: I demand narcotics and/or other medications for control of pain and suffering, but refuse to be transferred to the hospital for surgery or other interventions if the purpose is to prolong my life. I consider this "rescue" inappropriate.

I want caring and supportive nursing and medical care including narcotics and/or other medications to control pain and other suffering even if those medications might depress respiration or might hasten my death. My concerns are for comfort, personal hygiene, and consideration of the needs of my loved ones.

I want hospice care to be considered for me at the earliest appropriate time in the course of my illness or condition: this means that my physician(s) must be realistic in their prognosis—their evaluation of the prospects for improvement of that illness or condition.

I wish to reemphasize that if I am unable to give informed consent to health care decisions, and if the best available medical opinion is that there is little or no likelihood that my illness or condition will ever improve meaningfully, it is my wish to die in the normal course of events without benefit of life-prolonging medical intervention. I specifically do not want interventions including, but not limited to: dialysis, respirator/ventilator, CPR, pacemaker, transfusion.

(signature)_____ (date) _____

This page must be signed and dated the same day as the Advance Health Care Directive if it is to have the same force of law as that document.

Congratulations! (this is what we would say after you had completed your Advance Directive)

You have now executed a legal **Advance Health Care Directive.** It is an excellent document, but after all, only a piece of paper. It is extremely important to discuss this document, and any further thoughts you might have on this subject, with your family and your primary care doctor. It is a good idea to review this document every couple of years to make certain it still represents your wishes-—and that you know where it is! You can date and initial your review.

Please remember that no Advance Directive will even be consulted in an emergency. Paramedics and others will do what they need to do for you, including Cardio-Pulmonary Resuscitation. If you should decide that you don't want CPR, you must complete either a Pre-Hospital Do Not Resuscitate Order, or a POLST (Physician Orders for Life-Sustaining Treatment) specifying "Do Not Attempt Resuscitation" and have that order evidenced with a Medic-Alert bracelet or medallion saying "Do Not Resuscitate-EMS".

What should you do with your completed **Advance Health Care Directive?**

- keep the original with your important papers in a safe place at home (copies are legal)
- make sure your primary care doctor and other treating physicians have copies
- have a copy made part of your hospital record. Note: Many hospitals nowadays request additional copies if you are transferred to a different floor or level of care.
- give your agent and alternate agents copies
- you may want to: note on your cell phone that you have an AD and name your Agent; carry a copy in the glove box of the car; give your lawyer a copy
- Compassion and Choices will make a CD of your AD for you in return for a $100.00 contribution: www.compassionandchoices.org

A couple of excellent books:

Colby, William H., Long Goodbye, The Deaths of Nancy Cruzan; Hay House, 2002

Lynn, Joanne MD, Handbook for Mortals, Guidance for People Facing Serious Illness: George Washington University, 1999

Some useful websites on Advance Care Planning

www.caPOLST.org
http://www.emsa.ca.gov/pubs/pdf/DNRForm.pdf
www.caringinfo.org
www.nhpco.org (download state specific advance directives)
www.compassionandchoices.org
www.finalchoices.org
www.uslivingwillregistry.com
www.leginfo.ca.gov
www.cmanet.org
www.abanet.org
www.codaalliance.org

Some useful local resources

Health Library and Resource Center, El Camino Hospital, Mountain View, 650 940-7210
Coda Alliance, 2671 Plummer Ave San Jose, CA 95125 - 408 267-3922

This Advance Directive, dated __ __ __ revokes all previous advance directives.

Advance Health Care Directive

(in accordance with California Probate Code Sections 4600-4805)

PROTECTING YOUR HEALTH CARE FUTURE

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 lets you do either or both of these things. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1: Power of Attorney for Health Care

(1.1) Designation of agent:

(Fill in below the name and contact information of the person and alternate persons you wish to make health care decisions for you if you become incapacitated. You should make sure this person agrees to accept this responsibility. Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

If you choose to name an agent, you should discuss your wishes with that person and give him/her a copy. If you choose not to name an agent, just draw a line through the spaces below and go on to Part 2.)

I, _____ (date of birth) _____hereby appoint:

name_____

address_____

home phone (____) _____ work phone (____) _____

cell phone (____) _____ email address _____

as my agent to make health care decisions for me as authorized in this document.

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available, I designate as my first alternate agent:

OPTIONAL: name _____

address_____

home phone (____) _____ work phone (____) _____

cell phone (____) _____ email address _____

If I revoke the authority or if my agent and first alternate agent or if neither is willing, able, or reasonably available, I designate as my second alternate agent:

OPTIONAL: name _____

address_____

home phone (____) _____ work phone (____) _____

cell phone (____) _____ email address _____

(1.2) Agent's Authority: My agent is authorized to 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, 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 mark the following box. If I mark this box □, 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 have given 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 in 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 Postdeath 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, in the order designated.

Part 2: Instructions for Health Care

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

(2.1) End-of-Life Decisions: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

□ (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

□ (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) Relief from Pain: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(add additional sheets if needed)

(2.3) Other Wishes: (If you do not agree with any of the optional choices and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

_____

(add additional sheets if needed)

Part 3: Donation of Organs at Death (optional)

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

☐ (a) I give any needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only.

(c) My gift is for the following purposes (strike any of the following you do not want):
(1) Transplant
(2) Therapy
(3) Research
(4) Education

Part 4: Primary Physician (Optional)

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

(name & phone # of physician) _____

(address, city, state, zip)_____

Optional: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name & phone # of physician) _____

(address, city, state, zip)_____

Part 5:

(5.1) Effect of Copy: A copy of this form has the same effect as the original.

(5.2) Signature: Sign and Date the form here:

(date) _____ (sign your name)_____
(print your name)_____
(address, city, state, zip)_____

(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 health care 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 health 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:	Second Witness:
(print name)_____	(print name)_____
(address)_____	(address)_____
(city, state)_____	(city, state)_____
(signature)_____	(signature)_____
(date)_____	(date)_____

(5.4) At least one of the witnesses must 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 his or her death under a will now existing or by operation of law. (signature) _____

(Document may be notarized instead of witnessed if desired).

Part 6: Special Witness Requirement

(6.1) The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. 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 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.
(date)_____ (sign your name) _____
(address, city, state)_____
(print your name)_____