Advance Healthcare Directive

An easy-to-understand guide
to help you make healthcare choices
for the future

For more on why every adult
needs an Advance Healthcare
Directive, turn the page

To skip the introduction
and start making choices,
go to page 6
Why Every Adult Should Have an Advance Healthcare Directive

If you’re reading this, you’ve taken the first step toward completing an Advance Healthcare Directive.

Why continue? Why do this now?

Because an advance directive allows you to make sure your wishes will be known if you are ever unable to speak for yourself.

It’s important to plan ahead and make your healthcare preferences clear whether you’re young or old, healthy or sick. This may be part of end-of-life planning that also includes steps such as writing a will. Or, if you’re young and in good health, it may be a precaution you take in case you are injured in an accident or suddenly become ill and are unable to make decisions even for a short time.

Think of it as a kind of insurance — something you can do now to protect your quality of life in the future, and to protect those close to you from the emotional burden of having to make difficult healthcare decisions for you without knowing your wishes.

Among the choices you can make is naming someone to serve as your healthcare “agent” — perhaps your spouse or significant other, a sibling or a close friend. Choosing someone you trust to represent your best interests is a very effective way to make sure you always have a voice in your healthcare.

You don’t need a lawyer to make your advance directive legal and valid. Just follow the step-by-step instructions in this booklet and sign in front of two witnesses or a notary public.

But don’t stop there. It’s just as important, if not more so, to talk about your healthcare wishes with your agent, physician and all those who would be at your side in a health crisis.

These conversations can be very difficult. They bring up tough questions: What makes life worth living to you? Do you want your doctor to use medical technology to prolong your life? What if there is little or no hope of recovery?

It takes honest discussion about your answers to questions like these, and advance planning, to make sure that you will always have a say in your healthcare, and that your care will reflect your goals and wishes to the greatest extent possible. The sooner you start, the better.
How to Use This Booklet

This booklet is designed to make it easy for you to make healthcare plans for the future. The *Advance Healthcare Directive form on pages 6 to 19* allows you to put your wishes in writing to guide those who may need to make difficult decisions about your care if you are unable to communicate. In the back section, beginning on page 20, you will find important information and an additional form to assist you in your planning.

At the bottom of each page are directions to help you make choices about which parts you want to fill out. You will also find tips, definitions and additional information in green boxes throughout this booklet.

Making This Form Work for You

Feel free to cross out words, add as much explanation as you want or skip any portion of the first two parts. **The only required section is Part 3, where you sign in the presence of two witnesses OR a notary public.**

When you have completed this booklet, you can pull out the pages to make them easy to copy, or leave them as is if you prefer. **Be sure to give a copy to your healthcare agent (see page 6), physician and anyone else you want to include, and discuss your wishes with them as well.**

**You can change or cancel your Advance Healthcare Directive at any time. To learn how, go to page 20.**

Before completing this form, you may want to go to page 22 and review “Discussing Your Wishes,” a guide to help you clarify and discuss your end-of-life wishes.
Part 1: Choose a healthcare agent.
Select someone you trust to make healthcare decisions for you if you’re too ill to make them yourself.

Part 2: Make your healthcare choices.
You can make a general choice about whether or not you want your life prolonged under certain conditions. You also have the option of writing more specific instructions about the type of healthcare you want and don’t want.

Part 3: Sign the form.
To make this document legal and valid, it MUST be signed in the presence of two witnesses — adults who are personally known to you — or a notary public.

More Information
Answers to Commonly Asked Questions About Healthcare Planning ........................................... 20
Learn more about the advance healthcare planning process and some of the key words in this booklet.

Discussing Your Wishes ................................................................. 22
A form to help you clarify and discuss your goals and wishes.

Additional Resources ................................................................. Inside Back Cover
Where to go for more information and support.
Part 1: Choose a Healthcare Agent

In this section you can name a trusted individual to make healthcare choices for you if you are not able to make your own decisions.

Who should I choose to be my healthcare agent?

A family member or friend who:
- is 18 or older
- knows you well
- is willing to accept this responsibility
- can be trusted to honor your wishes
- is able to make difficult decisions
- can remain calm and think clearly
- can communicate effectively with healthcare providers and family members

Your agent cannot be your doctor or someone who works at the hospital or clinic where you are receiving care, unless he/she is a family member.

What kind of decisions can my healthcare agent make?

- Decide where you will receive care.
- Select or dismiss healthcare providers.
- Agree with or say no to medications, tests and treatments.
- Say what happens to your body and organs after you die.
- Take legal action needed to carry out your wishes.

How can I help my healthcare agent speak for me?

- Ask if he/she is willing to speak on your behalf — to work with your doctors to make sure your wishes are honored to the greatest extent possible.
- If the answer is “yes,” talk with your agent about your healthcare preferences and the reasons behind the choices you write down in your Advance Healthcare Directive.
- Be sure to discuss what (if any) quality of life you would find unacceptable, what (if any) aggressive measures you would tolerate and what sort of odds you must have to try or continue these measures. (See page 10 for definitions of some of the most commonly used life-sustaining procedures.)

What will happen if I do not choose a healthcare agent?

If you are unable to make your own decisions, your doctors will ask those closest to you to make healthcare choices for you. You can guide loved ones and physicians by completing Part 2 of this form, which begins on page 10.
Part 1: My Healthcare Agent

I want this person to speak for me if healthcare decisions need to be made and I am unable to communicate. My agent will represent my interests to the best of his/her ability, considering what he/she knows about my goals and wishes as well as any preferences I have expressed in this document:

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<tr>
<th>FIRST AND LAST NAME</th>
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<tr>
<td>ADDRESS</td>
</tr>
<tr>
<td>CITY</td>
</tr>
<tr>
<td>STATE</td>
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<tr>
<td>ZIP</td>
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</table>

| HOME PHONE NUMBER   |
| WORK PHONE NUMBER   |
| CELL PHONE NUMBER   |

| EMAIL ADDRESS       |

**OPTIONAL ALTERNATE #1:** If my agent is not willing, able or reasonably available to make healthcare decisions for me, I name as my first alternate agent:

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<td>CITY</td>
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<td>STATE</td>
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<td>ZIP</td>
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| WORK PHONE NUMBER   |
| CELL PHONE NUMBER   |

| EMAIL ADDRESS       |

**OPTIONAL ALTERNATE #2:** If my agent is not willing, able or reasonably available to make healthcare decisions for me, I name as my second alternate agent:

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<tr>
<td>ADDRESS</td>
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<tr>
<td>CITY</td>
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<tr>
<td>STATE</td>
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<td>ZIP</td>
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| HOME PHONE NUMBER   |
| WORK PHONE NUMBER   |
| CELL PHONE NUMBER   |

| EMAIL ADDRESS       |

Continue Part 1 and choose when your healthcare agent can speak for you on the next page.
Part 1: My Healthcare Agent’s Authority

When My Agent Can Speak for Me

My agent can begin to represent me when my physician says I am unable to make my own healthcare decisions.

INITIAL HERE

OR

My agent can immediately begin to make healthcare decisions for me.

INITIAL HERE

Limits and/or Special Instructions for My Healthcare Agent

In addition to carrying out the wishes expressed in the following pages of this document, my agent also must respect the limits and/or follow the special instructions specified below when making healthcare decisions for me.

Agent’s Authority After My Death

My agent can make decisions for me about organ donation, whether an autopsy is done and what happens to my remains, except as I state here or in Part 2 of this form.

Feel free to add pages if you need more space in the two sections above. Sign and date each additional page when you sign this form on page 15 in the presence of witnesses or a notary public.

Provide your physician’s name on the next page

If you want to skip to Part 2, “Make Your Healthcare Choices,” go to page 10
Part 1: My Physician

You can name a physician you trust to be involved in making decisions about your care. Ideally, this should be a physician you have been seeing on a regular basis who understands your goals and wishes.

I designate the following individual as my physician:

NAME OF PHYSICIAN

ADDRESS

CITY  STATE   ZIP

OFFICE PHONE NUMBER  CELL PHONE (IF AVAILABLE)  EMAIL ADDRESS

My Alternate Physician

I designate the following individual as my alternate physician:

NAME OF PHYSICIAN

ADDRESS

CITY  STATE   ZIP

OFFICE PHONE NUMBER  CELL PHONE (IF AVAILABLE)  EMAIL ADDRESS

Be sure to let your physician (and alternate) know you are naming him/her in your advance directive.

Please provide a copy of your Advance Healthcare Directive to the physician(s) named above and discuss your goals and wishes with him/her/them. Be sure to clarify what (if any) quality of life you would find unacceptable, what (if any) aggressive measures you would tolerate and what sort of odds you must have to try or continue these measures. (See page 10 for definitions of some of the most commonly used life-sustaining procedures.)

Go to Part 2, “Make Your Healthcare Choices,” on the next page

If you want to skip Part 2 and go directly to signing, go to page 15
Part 2: Make Your Healthcare Choices

You can provide instructions in this section about any aspect of your healthcare; just use the extra space on pages 12 and 13 or add pages as needed to explain your wishes. On the next page, you can say how you feel about the use of mechanical life support to prolong your life.

Sometimes this type of medical technology is needed only for a short time. For example, a feeding tube may be used to provide nutritional support if you are going through treatment and are temporarily unable to eat or drink. And equipment such as a respirator or dialysis machine may be used to help manage a chronic health problem.

The choices on the next page refer to situations in which you would be unable to survive without mechanical life support. The crucial question is: Do you want your life to be sustained artificially if you are so ill that further treatment would be very unlikely to result in meaningful recovery?

If your answer is “yes,” following are some of the procedures that may be used to sustain your life. Having a discussion with your doctor about the benefits and burdens of these measures is a good way to prepare to make choices on the next page.

- **Cardiopulmonary resuscitation (CPR):** If your heartbeat and/or breathing stop, CPR can be done to try to revive you. This may involve artificial respiration, forceful pressure on the chest, electric shock to the heart and/or drugs. There is a risk of breaking ribs and puncturing lungs, and survival may require remaining on mechanical life support. While CPR may restart the heart, it rarely returns even those who are otherwise healthy to their previous state of health, and the success rate is very low for those with illnesses that require hospital care.

- **Artificial nutrition and fluids:** If you’re unable to eat or drink, nutrition and fluids can be given through a tube inserted in your nose or directly into your stomach through a small incision. As with any medical treatment, there is a risk of complications and discomfort. If you prefer not to have a feeding tube, you can be kept comfortable. It is natural for dying patients to have little or no appetite.

- **Respirator or ventilator:** This is a machine that breathes for you if your lungs are not functioning properly. Oxygen is given through a tube in the nose or mouth. This may sustain your life, but if you are gravely ill and your condition is irreversible, being on a respirator may prolong the dying process.

- **Dialysis:** When the kidneys are no longer working properly, this mechanical process can be used to remove waste, salt and excess water so they don’t build up in the body. This involves inserting two small tubes, one in a vein and the other in an artery. These tubes carry blood from the patient into the dialysis machine, where it is filtered, and then back to the patient. As with a respirator or ventilator, dialysis does not treat most underlying illness, and may prolong the dying process.

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Continue with Part 2, “End-of-Life Care Decisions,” on the next page

If you want to skip Part 2 and go directly to signing, go to page 15
Part 2: End-of-Life Care Decisions

I direct that my physician and others involved in my care provide, withhold or withdraw treatment according to the choices I have marked below.

Choice **NOT TO** Prolong Life (Allow Natural Death):

Write your initials next to all the choices that match your wishes.

I do **NOT** want my life to be prolonged artificially under these circumstances:

1. I am close to death and mechanical life support would only prolong the dying process; INITIAL HERE
2. I am unconscious and doctors don’t expect me to wake up; INITIAL HERE
3. I have a terminal illness and there is little or no likelihood that my illness or condition is reversible or will improve substantially. INITIAL HERE

Choice **TO** Prolong Life:

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

INITIAL HERE

Completing this section gives you a chance to guide your healthcare agent, physician(s) and anyone else who may have to make choices for you under difficult circumstances.

If you choose NOT to prolong life, you will still receive treatment to prevent and relieve pain and suffering.

If you choose to prolong life, your physician may use measures such as the ones described on the preceding page. To explain your wishes or add instructions, go to page 13. For a definition of “generally accepted healthcare standards,” see page 20.

Continue with Part 2, “Comfort and Quality of Life,” on the next page.

If you want to skip to Part 2, “Organ and Tissue Donation,” go to page 14.
Part 2: Comfort and Quality of Life

INITIAL HERE  I want treatment to relieve pain and suffering to be provided as needed.

Please describe any exceptions to the statement above, or to the statements you initialed on page 11. Feel free to add pages if you need more space.

INITIAL HERE  I want palliative care experts to be part of my healthcare team so they can help provide pain and symptom relief.

INITIAL HERE  If I am NOT expected to recover, I want hospice care to be considered for me at the earliest appropriate time.

If you want to skip to Part 2, “Organ and Tissue Donation,” go to page 14.

If you add pages to this form, sign and date each additional sheet at the time you sign on page 15 in the presence of witnesses or a notary public.
Part 2: Explain Your Wishes or Add More

If you would like to explain any of your choices, or add information to help others understand your wishes, you may do so here. This is a good place to mention any cultural/religious views that influence your healthcare choices or end-of-life planning. Feel free to add pages if you need more space.

If you add pages, sign and date each additional sheet at the time you sign on page 15 in the presence of witnesses or a notary public.
# Part 2: Organ and Tissue Donation

Becoming an organ and tissue donor when you die can save lives and improve quality of life for others. Below are some choices for you to consider.

Choose one by initialing in the box. Upon my death:

<table>
<thead>
<tr>
<th>Choice</th>
<th>Initial Here</th>
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<tr>
<td>I want to donate any needed organs or tissues.</td>
<td></td>
</tr>
<tr>
<td>I give the following organs or tissues only.</td>
<td></td>
</tr>
<tr>
<td>I do not give any of my organs or tissues, and I do not want anyone who represents me to make a donation on my behalf.</td>
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If you have chosen to be a donor (above), indicate what your gift can be used for:

<table>
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<tr>
<th>Use</th>
<th>Initial Here</th>
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<tr>
<td>Wherever it is needed</td>
<td></td>
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<tr>
<td>Transplant</td>
<td></td>
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<tr>
<td>Other Medical Treatments</td>
<td></td>
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<tr>
<td>Research</td>
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<tr>
<td>Education</td>
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If you want to learn more about which organs or tissues can be donated, or register as a donor, go to donatelifecalifornia.org.

Your signature in the presence of two witnesses or a notary public is required on the next page.
Part 3: Sign the Form

You must sign this form in the presence of two witnesses OR a notary public to make it legal and valid.

Your witnesses must:

- be over 18
- know you
- see you sign this form

Your witnesses cannot:

- be your healthcare agent
- be your healthcare provider
- work for your healthcare provider
- work at the place where you live

One of your witnesses must be someone who is not related to you in any way and does not benefit financially by inheriting money or property after you die.

Your signature goes here:

NAME (SIGN YOUR NAME)       DATE

PRINT YOUR NAME

ADDRESS

CITY       STATE       ZIP

If you’re signing with witnesses, go to the next page

If you’re using a notary public, go to page 18
Part 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 Healthcare 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 Healthcare 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 Healthcare Directive; and 5) that I am not the individual’s healthcare provider, 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:

 NAME (SIGNATURE OF FIRST WITNESS) DATE

 PRINT YOUR NAME

 ADDRESS

 CITY STATE ZIP

Second Witness:

 NAME (SIGNATURE OF SECOND WITNESS) DATE

 PRINT YOUR NAME

 ADDRESS

 CITY STATE ZIP

If you live in a nursing home, go to page 19

One witness must sign the statement on the next page.
Part 3: Additional Witness Statement

At least one of your 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 Healthcare 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 OF WITNESS

DATE

If you live in a nursing home, a patient advocate or an ombudsman must sign on page 19.
PART 3: SIGN THE FORM (CONTINUED) > NOTARY PUBLIC

ALTERNATIVE TO SIGNING WITH WITNESSES

Part 3: Notary Public

You may use this certificate of acknowledgement before a Notary Public instead of the Statement of Witnesses:

State of California

County of ____________________________________

On _________________ before me, __________________________,

DATE HERE INSERT NAME AND TITLE OF THE OFFICER

personally appeared ________________________________

NAME(S) OF SIGNER(S)

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 __________________________

SIGNATURE OF NOTARY PUBLIC

PLACE NOTARY SEAL ABOVE
Part 3: Special Witness Requirement

If you are a patient in a nursing home or 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 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.

______________________________
NAME (SIGNATURE OF PATIENT ADVOCATE OR OMBUDSMAN)

______________________________
DATE

______________________________
PRINT YOUR NAME

______________________________
ADDRESS

______________________________
CITY  STATE  ZIP

The following pages provide important additional information
Answers to Commonly Asked Questions About Healthcare Planning

What should I do if I change my mind about the choices I made in this form?

You can change your choices at any time. If you want to make a change regarding your healthcare agent, you must do so in writing, with your signature, or by personally telling the supervising healthcare provider. You can change your healthcare choices in any way that communicates your intention. The best way to prevent confusion is to discard your existing Advance Healthcare Directive and complete a new one — and inform all those who need to know, including your doctor. Review your advance directive periodically to make sure it reflects your current wishes. It will remain valid unless you cancel it, complete a new one or specify a date when you would like it to expire.

How do I make healthcare choices that are not on this form?

You can write down your choices on additional sheets of paper. Sign and date each added page when you sign this form in the presence of witnesses or a notary public, and keep the extra pages with your advance directive. Talk about what you’ve written down with your loved ones, healthcare agent and physician, and continue to discuss your wishes as your circumstances and feelings change.

Who will my doctors talk to about my care if I don’t choose a healthcare agent?

Whether or not you have chosen a healthcare agent, your doctors will always be expected to exercise their best medical judgment and provide life-sustaining treatments within the limits of generally accepted healthcare standards. If you have not chosen an agent, your doctors are still required to discuss your condition and medical options with the individual(s) closest to you. This could be, for example, a family member, significant other or friend. In cases where no one close to you can be found and consent is needed, the medical center may ask the court to appoint a person to make decisions for you.

What does “generally accepted healthcare standards” mean?

Modern technology makes it possible to sustain life even when there is no reasonable hope of achieving meaningful treatment results. Generally accepted healthcare standards guide physicians in making tough treatment decisions. Physicians will do everything possible to sustain your life if your advance directive indicates this is what you want, but there are ethical limits to what they can do. For example, it would not be appropriate to start or continue treatments that would be unlikely to achieve meaningful results and may cause pain and suffering.

What if I don’t have an advance directive?

You will receive medical care regardless of whether or not you complete this form, but an advance directive gives you a chance to make your wishes known in case you become too ill to do so in the future.

If I name a healthcare agent, will this person be responsible for paying my medical bills?

Naming a healthcare agent in your advance directive does not give this individual any responsibility to meet your financial obligations, or any authority to make financial decisions for you. A lawyer can help you if you want to appoint someone to have financial power of attorney in case you are ever unable to make your own financial decisions.
QUESTIONS ABOUT HEALTHCARE PLANNING (END OF SECTION)

Where should I keep my Advance Healthcare Directive?

Once you have completed this form, you’ll want to make sure it can be found quickly if it is ever needed. Keep your original signed document in a secure but easily accessible place. **Give copies to your healthcare agent, loved ones and lawyer, and ask your doctor to make it part of your permanent medical record.** If you live in a nursing home or you are admitted to a hospital, have a copy of your advance directive placed in your medical record.

What is a POLST form and do I need one, or is my advance directive enough?

POLST, which stands for Physician Orders for Life-Sustaining Treatment, is a physician’s order that outlines a plan of care for patients who are near the end of life. It does not replace your advance directive but is an important additional step in advance healthcare planning. The form gives instructions such as whether to provide full treatment, limited treatment or comfort measures only, based on your doctor’s best medical judgment and your treatment preferences. This form also lets paramedics and others know if you want cardiopulmonary resuscitation (CPR) if you have no pulse and are not breathing.

The POLST form may be completed during a regular medical appointment or as part of the hospital discharge process, at any time that is appropriate for end-of-life planning. Once it is signed by both you and your physician, it becomes part of your medical record that goes with you if you are transferred from one hospital to another. Keep a copy on your refrigerator door or at your bedside where it would be easy to find in an emergency.

If I choose “comfort measures only,” will all medical care be stopped?

No. This just means the focus of care will change from prolonging your life with measures that may cause additional pain and suffering to keeping you as comfortable as possible. The expertise that palliative care and hospice services bring to patient care can make a tremendous difference in quality of life for those who choose “comfort measures only.”

What is palliative care, and how is it different from hospice care?

Palliative care provides relief from symptoms such as pain, nausea and depression, and also provides support for patients and their families. This care, provided in the hospital by palliative care experts in consultation with your other physicians, often is confused with hospice care, which is provided at home or in a community hospice facility for terminally ill patients with six months or less to live. Palliative care is not just given at the end of life, although it is an important part of care for the terminally ill. It also plays a crucial role in improving quality of life for patients with a variety of chronic disorders, including cancer and congestive heart failure, and may be offered along with curative treatments.

You may want to state in your advance directive that you want the palliative care team to be involved in your treatment as early as possible, and that you want to receive hospice referrals if further treatment to try to cure your illness would no longer achieve your goals and your doctor believes you have six months or less to live. Research shows that people with a terminal disease have better quality of life and sometimes live longer when comfort care begins sooner rather than later.

A form to help you clarify and discuss your end-of-life wishes starts on the next page
Discussing Your Wishes

This form is designed to help you clarify your feelings about end-of-life issues and discuss your wishes with those who may someday have to make difficult healthcare decisions for you.

Questions for Discussion

What’s most important to you when you think about quality of life? Circle a number on each line below to indicate how important each answer is to you on a 1–10 scale, with 10 being most important.

- Being mentally alert and competent.
- Interacting with the people I care about.
- Remaining independent in daily activities.
- Having a sense of peace and dignity.
- Being comfortable, which includes being as free from pain as possible.
- Not being connected to mechanical life support.
- Knowing that I am not a burden to others.
- Being able to enjoy small pleasures in daily life, such as listening to music, sitting in the sun, eating ice cream.

Also important to my quality of life are:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

INITIAL HERE

DATE
Do you have cultural/spiritual/religious beliefs that influence the way you feel about undergoing life-sustaining medical treatments at the end of life?

Do you want your life prolonged on mechanical life support no matter how sick you are, even if you are unconscious and not likely to ever wake up?

- Yes
- No

What are your preferences for the best possible scenario you can imagine when you think about your death? Make one choice on each line.

1. At home OR In a hospital, nursing home or other healthcare facility
2. Surrounded by loved ones OR Alone
3. Pain-free, even if it means not being conscious OR Able to interact, even if it means putting up with some discomfort
4. Free of medical equipment OR Connected to medical equipment that sustains my life

Other:

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INITIAL HERE DATE
DISCUSSING YOUR WISHES (CONTINUED)

How would you complete these sentences?
I will feel at peace when I die if:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The people I want at my bedside when I die are:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The people I specifically don’t want at my bedside are:

________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________

My sense of dignity will be preserved if:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
DISCUSSING YOUR WISHES (CONTINUED)

What I fear most about dying is:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

I want my loved ones to know that:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

I want my doctors to know that:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Before I die I want to:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
My wishes regarding funeral/burial/cremation are:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Include additional pages if you want to provide specific funeral/memorial service instructions with your Advance Healthcare Directive.

Optional Signature

My signature below means I have completed this form to provide additional information to help the individuals closest to me, including my healthcare agent, and my physicians to understand my end-of-life wishes.

I want the choices in my Advance Healthcare Directive to be honored as legally required, and I want the answers in this form to be considered as well because they provide more details about my goals and wishes.

NAME (SIGN YOUR NAME)      DATE
Additional Resources

Cedars-Sinai Medical Center

Palliative Care Services, (310) 423-9520
Cedars-Sinai’s Palliative Care Services helps patients who are facing life-threatening or advanced illnesses to have the best possible quality of life, and also provides support for families. Palliative care focuses on relieving a full range of symptoms, both physical and psychological, and is available to Cedars-Sinai patients along with all other appropriate treatments during any stage of illness.

Chaplaincy Program, (310) 423-5550
The Cedars-Sinai Chaplaincy Program offers spiritual care services to patients and their loved ones. This includes visits from the chaplain of your choice during your hospital stay, and assistance working through difficult issues related to end-of-life decisions and care.

Case Management, (310) 423-4446
The Case Management Department has clinical staff to assist patients with inpatient and post-hospital care that incorporates their values and preferences for treatment.

Center for Healthcare Ethics, (310) 423-9636 cedars-sinai.edu/ethics
The center offers clinical ethics consultations to help patients, family members, physicians and other members of the patient care team examine and discuss ethical values and goals in order to make morally appropriate and effective healthcare decisions. The center’s website includes information about advance directives.

Following are some websites that provide information on advance healthcare planning.

Advance Health Care Directive Registry — California sos.ca.gov/ahcdr

Aging With Dignity agingwithdignity.org

American Hospital Association putitinwriting.org

California Medical Association cmanet.com

Caring Connections caringinfo.org

Coalition for Compassionate Care of California coalitionccc.org and capolst.org (POLST forms in English and other languages)

Hospice Association of America nahc.org/HAA

U.S. Department of Veterans Affairs losangeles.va.gov/patients/advance.asp

Tear out the card below, fill in both sides, fold it on the dashed line and keep it in your wallet in case of an emergency.

POLST: PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT
I have a POLST form:
☑ Yes ☐ No

A copy of my POLST form may be obtained from:

<table>
<thead>
<tr>
<th>DOCTOR</th>
<th>PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER</td>
<td>PHONE</td>
</tr>
</tbody>
</table>

My wishes are:

Attempt resuscitation:
☑ Yes ☐ No

Prolong my life with artificial measures:
☐ Yes ☐ No

If “no” is checked, please contact my healthcare agent named on the front of this card before proceeding with CPR or mechanical life support.
I have an Advance Healthcare Directive.

Yes ☐ No ☐

My agent is:

1. NAME PHONE

2. NAME PHONE

A copy of my Advance Healthcare Directive may be obtained from:

NAME PHONE

MY NAME (PRINTED)

MY SIGNATURE