Advance Healthcare Directive

An easy-to-use form to make your goals, values and preferences known
Why Should You Have an Advance Healthcare Directive?

Whether you are young, old, healthy or sick, it is important to plan ahead and clearly state your healthcare goals, values and preferences. An Advance Healthcare Directive (“directive”) is the best place to do this. Your completed directive will give you greater peace of mind and provide comfort and guidance to the people in your life who may, at some point, be asked to speak on your behalf.

The process of filling out your directive may help you talk with loved ones about what matters most to you. There are also a number of resources available at Cedars-Sinai to help you complete your directive, including social workers, spiritual care experts and a free Advance Care Planning class. For information on these and other resources, please see the back cover of this document.
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SECTION A | CHOOSING MY HEALTHCARE AGENT

For help with filling out this section, please refer to pages 3–4 of the Step-by-Step Guide.

I choose the following person to speak on my behalf if at any time I am not able to (or choose not to) express my own goals, values and preferences:

Name: __________________________________________________________________
Relationship to You: __________________________________________________________________
Phone Number(s): __________________________________________________________________
Email Address (if known): __________________________________________________________________

The following person(s) can serve as alternate agents (this is optional):

First Alternate
Name: __________________________________________________________________
Relationship to You: __________________________________________________________________
Phone Number(s): __________________________________________________________________
Email Address (if known): __________________________________________________________________

Second Alternate
Name: __________________________________________________________________
Relationship to You: __________________________________________________________________
Phone Number(s): __________________________________________________________________
Email Address (if known): __________________________________________________________________
PART 1 (continued)

SECTION B  WHEN WOULD I LIKE MY HEALTHCARE AGENT TO BEGIN REPRESENTING ME?

For help with filling out this section, please refer to page 5 of the Step-by-Step Guide.

Please complete the sentence below by initialing either option 1 or option 2:

I would like my healthcare agent to begin participating in decisionmaking about my healthcare...

Option 1
...only when my physician determines that I am unable to express my own goals, values and preferences.

(Initial Here)

Option 2
...from this time forward, even if I am still able to speak for myself.

(Initial Here)
PART 2:
My Healthcare Goals, Values and Preferences

SECTION A | QUALITY OF LIFE

For help with filling out this section, please refer to pages 6–9 of the Step-by-Step Guide.

This section allows you to share what quality of life you would find acceptable. This information will help your medical team better understand who you are and what is most important to you. This can be a challenging topic — it can make you think about questions such as “what makes my life worth living?,” “what do I value most about my mental and physical health?” and “what would I not want to live without?”

Please complete the sentence below by selecting one option:

*My life would be worth living, and therefore I would want my life to be prolonged as long as possible, under the following circumstances:*

☐ All circumstances — even if it means only the basic functioning of my organs (heart, lungs, kidneys, etc.) with or without machines.

OR

☐ All circumstances, unless I would NEVER recover the ability to:

  **Physical and Bodily Considerations** (e.g., live without being permanently attached to life support machines, be able to walk):

  __________________________________________________________

  __________________________________________________________

  **Cognitive Considerations** (e.g., be conscious, know where I am, be able to think clearly):

  __________________________________________________________

  __________________________________________________________

  **Interactive, Social and Community Considerations** (e.g., communicate in some way with other people, live outside of a healthcare facility):

  __________________________________________________________

  __________________________________________________________

OR

☐ I am not sure.

If you would like to share additional details, please use page 6 or the extra pages provided at the end of this document.
SECTION B | SCOPE OF TREATMENT

For help with filling out this section, please refer to pages 10–11 of the Step-by-Step Guide.

Some people have ideas about which treatments they would be willing to receive and which ones they would not accept under any circumstances. This section is designed to help you communicate your preferences. If you do not have any specific ideas or preferences about treatment options, select the first option below. If you do have specific preferences, please write them in the space provided under the second option. If you are not sure, select the last option.

Please complete the sentence below by selecting one option:

*If my physician believes that I have a reasonable chance of recovering to the quality of life I stated in Part 2, Section A (on page 4), I would be willing to undergo the following:*

- ALL procedures, treatments and interventions offered by my healthcare team.

OR

- All procedures, treatments and interventions offered by my healthcare team, EXCEPT:

  ______________________________________________________
  ______________________________________________________
  ______________________________________________________
  ______________________________________________________
  ______________________________________________________
  ______________________________________________________
  ______________________________________________________

OR

- I am not sure.
If you would like to share more thoughts and information, you may do so here. This is a good place to mention any cultural or religious views that influence your healthcare goals, values and preferences.

If you would like to share additional details, please use the extra pages provided at the end of this document.
PART 3: How Strictly Do I Want My Advance Healthcare Directive Followed?

For help with filling out this section, please refer to page 12 of the Step-by-Step Guide.

Please complete the sentence below by initialing either option 1 or option 2:

I want my goals, values and preferences, as expressed in this directive...

Option 1
...to serve as a general guide.

(Initial Here)

Option 2
... to be followed strictly, under all circumstances.

(Initial Here)
PART 4 (OPTIONAL):
Additional Preferences

For help with filling out this section, please refer to page 13 of the
Step-by-Step Guide.

Organ Donation

☐ I wish to donate any and all organs and tissues.

OR

☐ I do not wish to donate any of my organs or tissues.

OR

☐ I wish to donate only the following organs or tissues (please specify):

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

My Wishes for After I Die

I have the following wishes regarding funeral, burial and/or cremation arrangements:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

If you would like to share additional details, please use the extra pages provided at the end
of this document.
PART 5 (OPTIONAL): Identifying My Physician

For help with filling out this section, please refer to page 13 of the Step-by-Step Guide.

You may have physicians involved in your care who understand your goals, values and preferences. If you would like them to be involved in discussions regarding your condition and treatment options, please list their names and contact information below.

Name of Physician: _____________________________________________________________________
Phone Number(s) (if known): ___________________________________________________________
Email Address (if known): ______________________________________________________________

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Phone Number(s) (if known): ___________________________________________________________
Email Address (if known): ______________________________________________________________

Please remember also to discuss your values and choices with the physician(s) named above and provide him/her/them a copy of your directive.
PART 6: Signing My Advance Healthcare Directive

For help with filling out this section, please refer to page 14 of the Step-by-Step Guide.

In order to make this document legal and valid, you must sign below. Your signature must be witnessed by either a **notary public** (Option 1, see page 13) or in the presence of **two witnesses** (Option 2, see page 14):

Name (Print):

__________________________________________________________________________________________

Signature:

__________________________________________________________________________________________

Date of Signature:

__________________________________________________________________________________________
OPTION 1: Signing My Advance Healthcare Directive With a Notary

NOTARIZATION
(California All-Purpose Acknowledgment, Civil Code 1189)

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, __________________________________________________________

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
OPTION 2:  
Signing My Advance Healthcare Directive 
With Witnesses

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, nor the employee of an operator of a residential care facility for the elderly; and 6) I am over 18 years of age.

WITNESS #1

Signature of Witness #1          Date

Printed Name of Witness #1        Phone Number

WITNESS #2

Signature of Witness #2          Date

Printed Name of Witness #2        Phone Number

One of the witnesses also 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 #1 or #2          Date
Special Witness Requirement

Note: For nursing home or skilled nursing facility patients only, a signature from a patient advocate or ombudsman is required in addition to completing either page 13 or 14.

If you are not in a nursing home or skilled nursing facility, you may skip this section.

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.

________________________________________________________________________________________
Signature of Patient Advocate or Ombudsman          Date

________________________________________________________________________________________
Printed Name of Patient Advocate or Ombudsman        Phone Number
Additional Resources

To sign up for the free Advance Care Planning Class, call 800-700-6424.

Cedars-Sinai Supportive Care Medicine, 310-423-9520
Cedars-Sinai’s Supportive Care Medicine (SCM) team helps inpatients and outpatients who are facing life-limiting or advanced illness to achieve the best possible quality of life, and also provides support for families. SCM clinicians are experts in managing a full range of symptoms, both physical and psychological; they are also specifically trained to help with Advance Care Planning and Advance Healthcare Directives.

Cedars-Sinai Spiritual Care, 310-423-5550; cedars-sinai.edu/spiritualcare
Members of the Cedars-Sinai Spiritual Care Department offer spiritual care services to Cedars-Sinai patients and their loved ones. Chaplains are available to visit patients and help work through difficult issues related to end-of-life decisions and care.

Cedars-Sinai Center for Healthcare Ethics, 310-423-9636; cedars-sinai.edu/ethics
For patients hospitalized at Cedars-Sinai Medical Center, the center offers clinical ethics consultation. The aim is to help patients, family members, physicians and other members of the patient care team examine and discuss pertinent ethical values and goals.

Cedars-Sinai Social Work
Inpatient: 310-423-4446    |    Outpatient: 310-248-8311

The following are some websites that provide information on advance healthcare planning:

- Advance Health Care Directive Registry — California; sos.ca.gov/registries/advance-health-care-directive-registry
- Aging With Dignity; agingwithdignity.org
- American Hospital Association; putitinwriting.org
- California Medical Association; cmanet.org
- 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; hospice.nahc.org
- Donate Life California – Organ and Tissue Donor Registry; donatelifecalifornia.org
- U.S. Department of Veterans Affairs; www.losangeles.va.gov/patients/advance.asp

Please send a copy of your signed, completed Advance Healthcare Directive to:
Fax: 310-248-8078    |    Email: groupMNSHID@cshs.org