

California Advance Health Care Directive

An Advance Directive lets you have a say about how you want to be treated if you get very sick.

This Advance Directive form has 4 parts. It lets you:

PART 1: Choose a medical decision maker.

A medical decision maker is a person who can make health care decisions for you if you are too sick to make them yourself.

PART 2: Make your own health care choices.

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what your wishes are if you are too sick to tell them yourself.

PART 3: Sign the form.

You must sign this form in front of witnesses before it can be used or given to your doctor.

PART 4: Make your Advance Directive legally valid.

To make valid in California, your Advance Directive must be signed by two witnesses, OR acknowledged before a Notary Public.



PART 1: Choose your medical decision maker

The person who can make health care decisions for you if you are too sick to make them yourself.

Whom should I choose to be my medical decision maker?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your decision maker cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

What will happen if I do not choose a medical decision maker?

If you are too sick to make your own decisions, your doctors will turn to family or friends to make decisions for you. This person may not know what you want.

What kind of decisions can my medical decision maker make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals, clinics, or where you live
- medications, tests, or treatments
- what happens to your body and organs after you die

Your decision maker will need to follow the health care choices you make in Part 2.

Other decisions your medical decision maker can make:

- **Life support treatments** - medical care to try to help you live longer
 - CPR or cardiopulmonary resuscitation
 - This may involve:
 - pressing hard on your chest to keep your blood pumping
 - electrical shocks to jump start your heart
 - medicines in your veins
 - Breathing machine or ventilator
 - The machine pumps air into your lungs and breathes for you.
 - You are not able to talk when you are on the machine.
 - Feeding Tube
 - A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.
 - Blood transfusions
 - To put blood in your veins.

- Dialysis

A machine that cleans your blood if your kidneys stop working.

- Surgery
- Medicines

- **End of life care** – if you might die soon, your medical decision maker can:
 - call in a spiritual leader
 - decide if you die at home or in the hospital
 - decide where you should be buried

PART 2: Make your own health care choices

Complete questions on form asking about your health care choices.

PART 3: Sign the form

Wait to sign this form until you are with either your two witnesses or notary public.

PART 4: Make your Advance Directive legally valid

Before your Advance Directive can be used, you must have 2 witnesses sign the form OR a notary public.

Your witnesses must:

- be over 18 years of age
- know you
- see you sign this form

Also, one witness cannot:

- be related to you in any way
- benefit financially (get any money or property) after you die

Your witnesses cannot:

- be your medical decision maker
- be your health care provider
- work for your health care provider
- work at the place that you live
(if you live in a nursing home see below).

If you do not have witnesses, a Notary Public must sign your advance directive below your signature.

- A Notary Public's job is to make sure it is you signing the form.
- Bring a photo I.D. (driver's license, passport, etc.) with you.

FOR CALIFORNIA NURSING HOME RESIDENTS ONLY

Give this form to your nursing home director ONLY if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

Common Questions about an Advance Directive

What if I change my mind?

- Fill out a new Advance Directive form.
- Tell those who care for you about your changes.
- Give the new form to your medical decision maker and doctor.

What if I have questions about the form?

Ask your doctors, nurses, social workers, friends or family to answer your questions. Lawyers can help too.

What if I want to make health care choices that are not on this form?

- Write your choices on the backside of the Advance Directive form.
- Share this form and your choices with your family, friends, and medical providers.

When do Advance Directives go into effect?

This form takes effect only when you can no longer make your own health care decisions. As long as you are able to give “informed consent,” your health care providers will rely on YOU and NOT your advance directives.

Where should I keep my Advance Directive?

- Provide original signed form to your healthcare team if you are being admitted to the hospital or at your next appointment. Your Advanced Directive will be scanned into your electronic medical record for everyone on your care team to access.
- Keep the original for yourself in a safe place that is easily accessible. You and your family should agree on a place to keep it.
- Give a copy to your Medical Decision Maker(s) and to others who you feel comfortable with: your spouse and other family members, your doctor, your lawyer, your clergy person, and nursing home where you may be residing.

I live in Nevada, is this California Advance Directive right for me?

No. You should complete an Advance Directive for State of Nevada. They are available at bartonhealth.org/advancedirective

I have an Advance Directive from another state, what should I do?

Provide it to your Barton Health care team. Out of state Advance Directives will be honored by all Barton Health System facilities.



My Advance Directive - My Legal Name is: _____

PART 1: My Medical Decision Maker

I want this person to make my medical decisions if I cannot make my own.

First Name	Last Name		
Primary Phone Number	Secondary Phone Number	Relationship	
Street Address	City	State	Zip code

If the first person cannot do it, then I want this person to make my medical decisions.

First Name	Last Name		
Primary Phone Number	Secondary Phone Number	Relationship	
Street Address	City	State	Zip code

How do you want your medical decision maker to follow your healthcare wishes?

Put an X next to the one sentence you most agree with.

- Total flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- Some flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these are some wishes I never want changed:

- No flexibility:** I want my decision maker to follow my medical wishes exactly, no matter what. It is NOT okay to change my decisions, even if the doctors recommend it.

To make your own health care choices go to Part 2 below. If you are done, you must sign this form on backside of form.

PART 2: Make Your Own Health Care Choices

Write down your choices so those who care for you will not have to guess. Think about what makes your life worth living.

My life is only worth living if I can (Put an X next to all the sentences you most agree with.):

- talk to family or friends
- wake up from a coma
- feed, bathe, or take care of myself
- be free from pain
- live without being hooked up to machines
- my life is always worth living no matter how sick I am
- I am not sure

If I am dying, it is important for me to be:

- at home
- in the hospital
- I am not sure

Is religion or spirituality important to you?

- no
 - yes
- If you have one, what is your religion? _____

What should your doctors know about your religious or spiritual beliefs?

Life Support Treatments - Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Please read this whole section before you make your choice. Put an X next to the one choice you most agree with.

- Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I want to stay on life support machines** even if I am suffering.
- Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I do NOT want to stay on life support machines.** If I am suffering, I want to stop and have life support removed.
- I do not want life support treatments,** and I want to focus on being comfortable. I prefer to have a natural death.
- I want my **medical decision maker** to decide for me.
- I am not sure.

Organ Donation - Your doctors may ask about organ donation after you die. Donating (giving) your organs can help save lives.

Please tell us your wishes. Put an X next to the **one** choice you most agree with.

- YES,** I want to donate my organs.
- NO,** I do **NOT** want to donate my organs.

If yes, which organs do you want to donate?

- any organ
- only _____
- I want my **decision maker** to decide.
- I am not sure.

What should your doctors know about how you want your body to be treated after you die?
Do you have funeral or burial wishes?



What other wishes are important to you?

PART 3: Sign this Form

Before this form can be used, you must:

- 1) sign this form if you are at least 18 years of age, and
- 2) have two witnesses sign the form or a Notary Public

Sign your name and write the date below.

Sign your name _____ Date _____

Print First Name _____ Print Last Name _____

Street Address _____ City _____ State _____ Zip code _____

PART 4: Witnesses Sign this Form

By signing, I promise that _____ (name) signed this form while I watched. He/she was thinking clearly and was not forced to sign it.

I also promise that:

- I know this person and he/she could prove who he/she was.
- I am 18 years or older
- I am not his/her medical decision maker
- I am not his/her health care provider
- I do not work for his/her health care provider
- I do not work where he/she lives

One witness must also promise that:

- I am not related to him/her by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after he/she dies

Witness #1

Sign your name _____ Date _____

Print First Name _____ Print Last Name _____

Street Address _____ City _____ State _____ Zip code _____

Witness #2

Sign your name _____ Date _____

Print First Name _____ Print Last Name _____

Street Address _____ City _____ State _____ Zip code _____

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. (Not required if signed by two witnesses.)

ACKNOWLEDGMENT OF NOTARY PUBLIC

State of California County of _____

On _____ before me, _____ (insert name and title of the officer) 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 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 _____

For California Nursing Home 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.”

Sign your name _____ Date _____

Print First Name _____ Print Last Name _____

Street Address _____ City _____ State _____ Zip code _____