

ADVANCE HEALTH CARE DIRECTIVE
California Probate Code Section 4701

of _____
(Patient Name)

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. It also lets you express your wishes regarding donation of organs. If you use this form, you may complete or modify all or any part of it. You are free to use a different form for your Advance Health Care Directive.

PART 1 – Healthcare Surrogate Decision Maker

Authority of Healthcare Surrogate Decision Maker

Your surrogate decision maker must make health care decisions that are consistent with the instructions in the document and your know desire. It is important that you discuss your health care desires with the person(s) you appoint as your surrogate healthcare decision maker and with your doctor(s). If your wishes are not known, your surrogate must make health care decisions that the surrogate believes to be in your best interest, considering your personal values to the extent they are known.

If my primary physician finds that I cannot make my own health care decisions, I grant my surrogate decision maker full power and authority to make those decisions for me, subject to any health care instructions set forth below. My surrogate will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.
5. Authorize donation of organs or tissue, authorize an autopsy, and direct the disposition of my remains in the event of my death.

I understand that, by law, my surrogate decision maker may not consent to committing me to or placing me in a mental health treatment facility or to convulsive treatment, psychosurgery, sterilization or abortion.

Designation of Surrogate Decision Maker

I designate the following individual to be my health care surrogate decision maker:

(Name) (Relationship)

(Address) (Phone)

OPTIONAL

If I revoke the authority of my surrogate or if my surrogate is not willing, able or reasonably available to make healthcare decisions for me, I designate the following as my first alternate surrogate decision maker:

(Name) (Relationship)

(Address) (Phone)

If I revoke the authority of my surrogate and first alternate surrogate, or if neither is willing, able or reasonably available to make healthcare decisions for me, I designate the following as my second alternate surrogate decision maker for health care:

(Name) (Relationship)

(Address) (Phone)

OPTIONAL

I place the following limits on my Healthcare Surrogate Decision Maker:

OPTIONAL

I want to put into effect now the authority of my surrogate decision maker, even though I am still able to make decisions for myself. I understand and authorize this statement as proved by my signature.

(Signature) (Date)

PART 2 – OPTIONAL Health Care Instructions

Life support or life sustaining treatments are any medical procedures, devices or medications used to keep you alive. Life support treatment may include: medical devices put in you to help you breathe; food and fluid supplied artificially by medical device (tube feeding); major surgery; blood transfusions; kidney dialysis and antibiotics.

You may, but are not required to, state your desires about the goals and types of medical care you do or do not want, including your desires concerning life support if you are seriously ill. If your wishes are not known, your surrogate decision maker must make health care decisions for you that the surrogate believes to be in your best interest, considering your personal values.

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die comfortably if (1) I am in an irreversible coma or persistent vegetative state or (2) if I am terminally ill and the use of life sustaining procedures would serve only to artificially delay the moment of my death, or (3) under any other circumstances where they burdens of the treatment outweigh the expected benefits.

PART 3 – Organ Donation

_____ **I wish to be an organ donor. See my driver's license for the attached page(s) for instructions.**

_____ **I do not wish to be an organ donor.**

You should only sign this form after all your questions have been answered and only in the presence of two qualified witnesses or in the presence of a notary public

(Sign your name here)

(Print your name here)

Document signed at _____

(City)

California on _____

(Date)

PART 5 – Witness Requirement

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged the 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 the Advance Health Care 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 appointed as surrogate decision maker by the Advance 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 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.

Print Name: _____

Address: _____

Signature: _____

Date: _____

Print Name: _____

Address: _____

Signature: _____

Date: _____

Additional Statement of Witness

At least one witness 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 Directive for Health Care 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: _____