

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

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 and the designation of your primary physician. 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 I of this form is “Power of Attorney” for health care. If you have a DPOA dated prior to 1992, please take a few minutes to update by using this updated form and discuss with your primary care physician, family members, loved ones and friends.

If you have a complaint specifically about Menlo Medical Clinic’s provision of information on advance directives, you may also contact:

Department of Health Services,
Licensing and Certification Division
1 Almaden Blvd., Floor 9
San Jose, CA 95113
(408) 277-1784
(408) 277-1032 (FAX)

If you are a Medicare patient with any complaints about Menlo Medical Clinic’s provision of information on advance directives, you may also call:

Medicare Hotline: 1 (800) 633-4227 (1-800-Medicare)



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PART I

POWER OF ATTORNEY FOR HEALTH CARE

Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably capable to make decisions for you. (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 you agent is related to you or is a co-worker.)

A. DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

(Name of individual you choose as your agent)

(Address) (City), (State) (Zip Code)

(Home Phone) (Work Phone) (Cell Phone)

First Alternate Agent Option: If I revoke my agent's authority, or if my agent is not willing, able, or reasonably available to make a health care decision as my first alternate agent:

(Name of individual you choose as your agent)

(Address) (City), (State) (Zip Code)



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PART II

INSTRUCTIONS OF HEALTH CARE

Part II lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Your choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive and also as the provision of pain relief. There is space available for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part II of this form.

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

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

B. 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 necessary)



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PART III
DONATION OF ORGANS AT DEATH (OPTIONAL)

Be sure to communicate your intentions to your family members, loved ones and physician(s).

Part III of this form lets you decide your intention to donate your bodily organs and tissues following your death.

DONATION:

A. Upon my death (mark applicable box)

(a) I give any needed organs (e.g., kidneys, liver, heart, lungs, pancreas, spleen) tissues (e.g., corneas, heart valve, skin, bones), or parts,

or,

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

AND,

PURPOSE:

(c) strike any of the following you do **NOT** want)

- Transplant
- Therapy
- Research
- Education

Patient's Signature

For more information on organ and tissue donation in California, contact the California Transplant Donor Network at www.ctdn.org or phone 1-888-570-9400.



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PART IV

PRIMARY PHYSICIAN (OPTIONAL)

Part IV of this form lets you designate a physician to have primary responsibility for your health care.

A. I designate the following physician as my primary physician:

(Name of Physician)

(Address, City, State, Zip)

(Phone)



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PART V

SIGNATURE AND WITNESS SECTION

Part V of this form is the signature and witness signature(s) and notary section.

A. EFFECT OF COPY: A copy of this form has the same effect as the original

B. SIGNATURE: Sign and date form here:

_____ (Sign Your Name) _____ (Date)

_____ (Print Your Name)

_____ (Address, City, State, Zip)

C. STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of California

- 1) that the individual who signed or acknowledged 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 agency by this advance directive, and
- 5) that I am not the individual's health care provider, an employee of the individual's healthcare 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.



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FIRST WITNESS:

_____ (Sign Your Name) _____ (Date)

_____ (Print Your Name)

_____ (Address, City, State, Zip)

SECOND WITNESS

_____ (Sign Your Name) _____ (Date)

_____ (Print Your Name)

_____ (Address, City, State, Zip)



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WITNESS my hand and official seal.

Notary Seal

EVIDENCE OF IDENTITY: A current California driver's license or identification card or US Passport.



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Part VI

SPECIAL WITNESS REQUIREMENT

Part VI of this form is a special witness requirement to be completed 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.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public.

You should keep the completed original and give copies of the completed original to the following:

1. your agent and alternate agents
2. your physician(s)
3. members of your family and others who might be called in the event of a medical emergency
4. any hospital or other health facility where you receive treatment.

Instruct your agent(s), family, and friends to provide a copy of your directive to your physician(s) or emergency medical personnel on request.



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**CONTACT LIST FOR PEOPLE WHO HAVE A COPY OF MY
ADVANCE HEALTH CARE DIRECTIVE**

You should give copies of your completed Advance Health Care Directive form to the following people:

- (1) Your agent and alternate agent(s),
- (2) Your physician(s) and health plan,
- (3) Your family members or anyone else who is likely to be called if there is a medical emergency, and
- (4) Any hospital or other health facility where you receive treatment.

You should also take a copy of the Directive with you if you are going to be admitted to a hospital, nursing home, or other health care facility.

This Contact List will help you to remember the people and health providers who have copies of your Directive so that you can contact them with updated information if you decide to revoke or change it. Remember to bring a copy of this Contact List with you if you are going to be admitted to a hospital, nursing home, or other health care facility.

Date of my Advance Health Care Directive: _____.
(date)

PEOPLE WHO HAVE A COPY OF MY ADVANCE HEALTH CARE DIRECTIVE

Name: _____ Name: _____

Address: _____ Address: _____

Phone(s): _____ Phone(s): _____



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ADVANCE HEALTH CARE DIRECTIVE
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Name: _____

Name: _____

Fax: _____

Fax: _____

Email: _____

Email: _____

Name: _____

Name: _____

Address: _____

Address: _____

Name: _____

Name: _____

Phone(s): _____

Phone(s): _____

Fax: _____

Fax: _____

Email: _____

Email: _____

Name: _____

Name: _____

Address: _____

Address: _____

Phone(s): _____

Phone(s): _____

Fax: _____

Fax: _____

Email: _____

Email: _____



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Name: _____

Name: _____

Address: _____

Address: _____

Phone(s): _____

Phone(s): _____

Fax: _____

Fax: _____

Email: _____

Email: _____

Name: _____

Name: _____

Address: _____

Address: _____

Phone(s): _____

Phone(s): _____

Fax: _____

Fax: _____

Email: _____

Email: _____