ADVANCE HEALTH CARE DIRECTIVE FORM

Date:

|  |  |  |  |
| --- | --- | --- | --- |
| Your Name: | Last | First | Middle initial |
| Street Address |  | City | State Zip |

Part 1: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

**The following statements only apply**

* if I am close to death and life support would only postpone the moment of my death **OR**
* if I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will everbecome conscious **OR**
* if I have brain damage or a brain disease that makes me permanently unable to make and communicate health-care deci-sions about myself.

(INITIAL ONLY ONE (1) CHOICE IN EACH SECTION and CROSS OUT ALL THAT DO NOT APPLY.)

**A. CHOICE TO PROLONG OR NOT TO PROLONG LIFE**

\_\_\_\_ YES, I do want to have my life prolonged as long as possible within the limits of generally accepted health-care standards that apply to my condition.

# OR

\_\_\_\_ NO, I do not want my life prolonged.

**B. ARTIFICIAL NUTRITION AND HYDRATION (FOOD AND FLUIDS) BY TUBE INTO STOMACH OR VEIN**

\_\_\_\_ YES, I do want artificial nutrition and hydration.

# OR

\_\_\_\_ NO, I do not want artificial nutrition and hydration.

**C. RELIEF FROM PAIN**

\_\_\_\_ YES, I do want treatment to relieve my pain or discomfort.

# OR

\_\_\_\_ NO, I do not want treatment to relieve my pain or discomfort.

1. **ETHICAL, RELIGIOUS, OR SPIRITUAL INSTRUCTIONS (OPTIONAL)**

Is there a church, temple, spiritual group or a special person from whom you wish to receive spiritual care?

Name: Phone

Street Address City State Zip

1. **DO YOU WANT HOSPICE CARE, IF APPROPRIATE?** \_\_\_\_ YES \_\_\_\_ NO

(Hospice provides physical, psychosocial, emotional, and spiritual support and counseling for the patient and his/her family.

Hospice is available in home, hospital, hospice-unit, and nursing home settings.)

1. **PRIMARY CARE PHYSICIAN**

Name: Phone

1. **OTHER WISHES:**

If you do not agree with any of the choices above or wish to add other instructions, including body and organ donation, you may add pages. If you are or could become pregnant, consult your doctor, and consider adding special instructions suspending or adding provisions. Remember to sign, date, witness or notarize additional pages. File a copy with:

■ Doctor copy ■ Family Copy ■ Agent Copy ■ www.myhealthdirective.com

PART 2: HEALTH-CARE POWER OF ATTORNEY AGENT’S AUTHORITY AND OBLIGATION

My agent shall make health-care decisions for me in accordance with my best interests and wishes so far as they are known. In determining my best interest, my agent shall consider my personal values. If a guardian of my person needs to be appointed for me by a court, I nominate my agent. I designate the following individual as my agent. He/she may make all healthcare decisions for me if I am unable or unwilling to make them for myself unless I direct otherwise:

Street Address City State Zip

Home Phone Work Phone E-mail

\_\_\_\_ My agent may make all health-care decisions for me. **OR**

\_\_\_\_ My agent may make all health-care decisions for me except: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

\_\_\_\_ My agent’s authority becomes effective when my primary physician determines that I am unable to make health-care decisions.**OR**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Agent (Spouse, adult child, frien | d or other trusted person) |  | Relationship |
| Street Address | City |  | State Zip |
| Home Phone Work Phone E-mail  If my agent is not available, I designate the following person as my alternative agent: | | |  |
| Name of Alternate Agent (Spouse, adult child, friend or other trusted person) | | | Relationship |

|  |  |  |  |
| --- | --- | --- | --- |
| Witness #1 Print Name | Witness Signature |  | Date |
| Address | City | State | Zip Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Witness #2 Print Name | Witness Signature |  | Date |
|  |  |  |  |
| Address | City | State | Zip Code |

\_\_\_\_ My agent’s authority to make health-care decisions for me takes effect immediately.

**YOUR NAME: Print Your Full Name Your Signature Date**

**WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.**

**Important: Witnesses** cannot be your health-care agent, a health-care provider or an employee of a health-care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

OPTION 2: Notary Public

State of Hawai‘i, \_\_\_\_\_\_\_\_\_\_\_\_\_ (County)

On this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_, in the year \_\_\_\_\_\_\_, before me, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (insert name of notary public) appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he or she executed it.

My Commission Expires:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy has the same effect as the original.

Developed by the Executive Office on Aging, State of Hawai‘i – Revised September 2003.





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in accordance with the Uniform Health Care Decisions Act,

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Complete Part 1 and 2 on the enclosed form. You may add pages a

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make any changes you wish. You do not need an attorney to complete this

form. If you need more help, consult the phone numbers included in this

brochure. Complete the check list on the back page.

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Give instructions to your doctor and others about any aspect of your

health care. You will be given choices. Check only one box in e

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category and cross out all which do not apply.

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**YOURAGENT**

Select one or more persons to be your agent and make health car

e deci-

sions if you are unable. The person you appoint can be a spouse, adult

child, friend, or any other trusted person. Your agent cannot be an owner

or employee of a health care facility where you are receiving c

are unless

they are related to you.

**Ask two witnesses to sign and date the form**

Both must be people you know. They cannot be health care provid

ers,

employees of a health care facility, or the person you choose as an agent.

One person cannot be related to you or have inheritance rights.

**Notary Public**

If you do not have 2 witnesses, your Advance Directive must be

notarized.

You have

**the right to revoke or change your Advance Directive at any**

**time**

orally or in writing. Be sure to tell your agent and doctor.

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**Kauai:**

Seniors Law Program

**808-246-0573**

**Maui, Molokai, Lanai:**

Legal Aid Society

**808-242-0724**

**Oahu:**

UH Elder Law Program

**956-6544**

**www.hawaii.edu/uhelp**

**Big Island:**

Legal Aid Society (Hilo)

**808-934-0678**

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Kona

**808-329-8331**

For further information contact:

**Kokua Mau**

Continuous Care) website at

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**www.kokuamau.org**

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**Kokua Mau Speaker’s Bureau: (800) 474-2113.**

Churches, Temples or

Spiritual Groups can ask about the Complete Life Course.

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Medical technology has given us many new options for sustaining life.

This makes it important for you to discuss what kind of care yo

u want

before serious illness or accident occurs.

Now is the time to talk about these important issues while you can still

make your own decisions and have time to talk about them with o

thers.

If you don’t have an Advance Directive and even one person inte

rested in

your care disagrees, your doctor may not honor your wishes for

end-of-life

care.

The Advance Directive takes the place of the former living will

document

and gives you more options. Review your existing forms to decide if an

Advance Health Care Directive will better reflect your wishes.

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You can say whether or not you want to be kept alive by machines that

breathe for you or feed you even if there is no hope you will get better.

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**OURWISHESFORCOMFORTCARE**

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You can indicate whether you want medicine for pain or where yo

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to spend your last days. You can also give spiritual, ethical, and religious

intructions.

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**AGENT**

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**FORYOUWHENYOUCANNOT**

**.**

This agent does not have to be an attorney. Unless you limit your agent’s

authority, your agent has the right to accept or refuse any kind of medical

care and testing, discharge or select doctors, and see all medical records.

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Share copies and talk with people who will be involved in your

care. Ask

your doctor to insert your Advance Directive into your medical

records.

Register your Advance Directive free of charge at www.MyHealthD

irec-

tive.com or call 587-4781.