California Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

This form has 3 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 you want if you are too sick to tell them yourself.

**Part 3: Sign the form.**
It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want. Always sign the form in Part 3.
2 witnesses need to sign on page 11 or a notary public on page 12.

YOUR NAME: _______________________________
If you only want to name a medical decision maker go to Part 1 on page 3.

If you only want to make your own health care choices go to Part 2 on page 6.

If you want both then fill out Part 1 and Part 2.

Always sign the form in Part 3 on page 9.
2 witnesses need to sign on page 11 or a notary public on page 12.

What if I change my mind?

• Fill out a new 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 page 9.

Share this form and your choices with your family, friends, and medical providers.
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**
  
  cardio = heart       pulmonary = lungs       resuscitation = to bring back

  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.

- **Dialysis**
  
  A machine that cleans your blood if your kidneys stop working.

- **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.

- **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

Show your medical decision maker this form.
Tell your decision maker what kind of medical care you want.
Your Medical Decision Maker

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

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

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Put an X next to the sentence you agree with.

- My medical decision maker can make decisions for me right after I sign this form.
- My medical decision maker will make decisions for me only after I cannot make my own decisions.

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 OK** to change my decisions, even if the doctors recommend it.

To make your own health care choices, go to Part 2 on the next page.

If you are done, you must sign this form on page 9.
If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

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?

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

YOUR NAME: __________________________
If I am so sick that I may die soon:

- 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.

- **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.

**If you want to write down medical wishes that are not on this form, go to page 9.**
Part 2: Make your own health care choices

Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

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

**Donating (giving) your organs can help save lives.**

- I want to donate my organs.
  
  Which organs do you want to donate?
  
  - any organ
  - only __________________________

- I do not want to donate my organs.
- I want my **decision maker** to decide.
- I am not sure.

**An autopsy can be done after death to find out why someone died.**

It is done by surgery. It can take a few days.

- I want an autopsy.
- I do not want an autopsy.
- I only want an autopsy if there are questions about my death.
- 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?

________________________________________________________________________________

________________________________________________________________________________

YOUR NAME: _____________________________
Part 2: Make your own health care choices

California Advance Health Care Directive

What other wishes are important to you?

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Part 3 Sign the form

Before this form can be used, you must:

• sign this form if you are at least 18 years of age
• have two witnesses sign the form or a notary public

Sign your name and write the date.

/ / 

sign your name date

print your first name print your last name

address city state zip code
Part 3  Witnesses

Before this form 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

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 go to page 12).

Also, one witness cannot:

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

If you do not have witnesses, a notary public must sign on page 12.

• A notary public’s job is to make sure it is you signing the form.

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public
and have them sign on page 12.
Have your witnesses sign their names and write the date

By signing, I promise that ______________________ signed this form while I watched. (name)

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 your first name print your last name

address city state zip code

Witness #2

/ / /
sign your name date

print your first name print your last name

address city state zip code

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes
**Notary Public** Take this form to a notary public **ONLY** if two witnesses have not signed this form. Bring photo I.D. (driver’s license, passport, etc.)

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**CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC**

State of California

County of ___________

On _________ before me, __________________________, 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

Signature of Notary Public

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**Description of Attached Document**

Title or Type of document: ____________

Date: ______ Number of pages: ______

Capacity(ies) Claimed by Signer(s)

☐ Individual

☐ Guardian or conservator

☐ Other ____________

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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.

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**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 your first name print your last name

address city state zip code

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This advance directive is in compliance with the California Probate Code, Section 4671-4675. http://www.leginfo.ca.gov/calaw.html

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