Advance Directive - CALIFORNIA

Providence St. Joseph Health

Step 1: Choose your health care representative.

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Think about the people in your life – your family and friends. Select someone to be your health care representative. Ask that person if he or she is willing to do this for you.

Choose a family member or friend who:

- Is 18 or older and knows you well
- Is willing to do this for you
- Is able to make difficult decisions based on your wishes
- Will effectively communicate the information you provide in this packet to health care providers and family members

Your health care representative can:

- Decide where you will receive care
- Select or dismiss health care providers
- Say yes/no to medications, tests, treatments
- Say what happens to your body and organs after you die
- Take legal action needed to carry out your wishes

Your representative **cannot** be your doctor or someone who works at the hospital or clinic where you are receiving care unless he or she is a member of your family.

Name your health care representative.

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

First name	Last name		Relationship	
Home/Cell phone	Work phone		Email	
Street address		City	State	ZIP code

If the first person cannot make my medical decisions, then I want this other person:

First name	Last name		Relationship	
Home/Cell phone	Work phone		Email	
Street address		City	State	ZIP code

2) Put an X next to the sentence you agree with:

___ My health care representative will make decisions for me **only** after I become unable to make my own decisions.

OR

___ My health care representative can make decisions for me **right now** after I sign this form.

This advance directive belongs to: (please print your name on this line)	**Date of Birth**

Step 2: Make your health care choices.

What makes your life worth living?

1) My life is (choose A or B):

___ A) Always worth living no matter how sick I am

___ B) Only worth living if (check all that are true for you):

- ___ I can talk with family and friends
- ___ I can wake up from a coma
- ___ I can feed, bathe or take care of myself
- ___ I can be free from pain
- ___ I can live without being hooked up to machines
- ___ I am not sure

2) If I am dying, it is important for me to be (choose one):

___ At home

___ In a hospital or other care center

___ It is not important to me where I am cared for

Religion or spiritual beliefs

1) Is religion or spirituality important to you?

___ Yes ___ No

2) Do you have a religion or faith tradition? If so, what is it?

_____

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

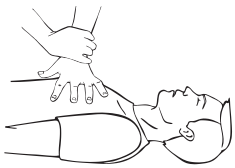
_____

_____

_____

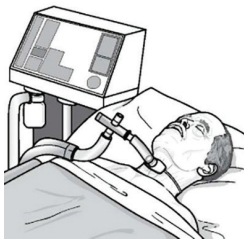
Step 2: Make your health care choices, continued.

Life support



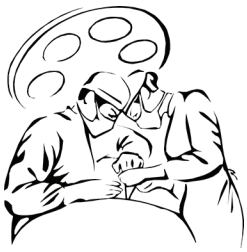
Life-support procedures may be used to try to keep you alive. They include:

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 — This machine pumps air into your lungs and breathes for you through a tube placed in your throat. You are not able to talk or eat when you are on the machine.

Dialysis — This machine cleans your blood if your kidneys stop working.



Feeding tube — This tube provides food to your body if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed surgically.

Blood transfusion — This will put blood in your veins.

Surgery and/or medicines

Put an X next to the <u>one</u> statement you most agree with.

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 life-support treatments to stop so that I can be allowed to die gently.

___ **I do NOT want life-support treatments.** I want to focus on my comfort. I prefer to have a natural death.

___ I want my **health care representative** to decide.

___ I am not sure what I would like done.

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Step 2: Make your health care choices, continued.

Donating your organs

Your doctors may ask about organ donation and an autopsy after you die. Donating your organs can help save lives. Put an **X** next to the **one** choice you most agree with.

___ I **want** to donate my organs:

- ___ Any organ, all that might be usable.
- ___ Only certain organs (please specify which organs or tissues you wish to donate).

_____

_____

___ I **do not** want to donate any of my organs.

___ I want my **health care representative** to decide.

___ I am not sure what I would like done.

Autopsy

An autopsy can be done after death to find out why someone died. It's a surgical procedure. It can take a few days. In some cases an autopsy may be required by law. Put an **X** next to the **one** choice you most agree with.

___ I **want** an autopsy.

___ I **do not** want an autopsy.

___ I want an autopsy **only if there are questions** about the cause(s) of my death.

___ I want my **health care representative** to decide.

___ I am not sure what I would like done.

Step 2: Make your health care choices, continued.

Other things to consider

What other wishes are important to you after you die? For example, are there any cultural, religious, or spiritual things about how to treat your body that your health care team should know?

Do you have someone who should be contacted for funeral or burial wishes? If yes, who?

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Step 3: Outline your health care representative's authority.

Your health care representative can help make the following decisions about:

Life-support treatments - medical care to help you live longer:

- CPR or cardiopulmonary resuscitation
- Breathing machine or ventilator
- Dialysis
- Feeding Tube
- Blood Transfusion
- Surgery
- Medicines

End-of-life care

If you might die soon, your health care representative can:

- Call a spiritual leader
- Decide if you die at home or in the hospital
- Decide whether an autopsy will be performed
- Decide whether your organs may be donated
- Decide where you should be buried or cremated

How do you want your health care representative to follow your medical wishes?

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

___ **Total flexibility:** It is OK for my health care representative to change **any** of my medical decisions if, after talking with my doctors, he/she thinks it is best for me at that time.

___ **Some flexibility:** It is OK for my health care representative to change **some** of my medical decisions if, after talking with my doctors, he/she thinks it is best for me at that time.

___ **Minimal flexibility:** I want my health care representative to follow my medical wishes as closely as possible. Please respect my decisions even if doctors recommend otherwise.

Use additional pages, if necessary, to answer the questions below.

These are some of my wishes I really want respected:

Write down any decisions you **do not** want your health care representative to make:

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Step 4: Sign the form.

Your signature

Before this form can be used, you must:

- Sign this form if you are at least 18
- Have two witnesses sign the form **or** have it notarized by a notary public

Sign your name and write the date.

Signature _____ Date _____

Print name _____

Street address _____ City _____ State _____ ZIP code _____

Witnesses

Before this form can be used, you must have two witnesses sign the form **or** a notary public notarize it.

Your witnesses must:

- Be at least 18
- Know you
- Acknowledge that you signed this form

Your witnesses cannot:

- Be the person you named as your health care representative
- Be your doctor or other health care provider
- Work for your medical center or health care provider
- Work at the place where you live

In addition, **at least one** witness must:

- Not be related to you in any way
- Not benefit financially - be eligible for any money or property - after you die
- Be an ombudsman or patient advocate if you live in a skilled nursing facility (see page 9)

If you do not have two witnesses, a notary public can sign on page 9.

Step 4: Sign the form, continued.

Witnesses' signatures

Have your witnesses complete this page.

By signing, I promise that _____ acknowledged that he/she signed this form.
Name of advance directive owner

I believe he/she was thinking clearly and was not forced to sign this form.

I also promise that:

- I know this person and he/she could prove who he/she was
- I am at least 18
- I am not his/her health care representative
- 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

Witness #1 (signing below) must also promise that:

- I am in no way related to him/her
- I will not benefit financially - be eligible for any money or property - after he/she dies

Witness #1

Signature _____ Date _____

Print name _____

Street address _____ City _____ State _____ ZIP code _____

Witness #2

Signature _____ Date _____

Print name _____

Street address _____ City _____ State _____ ZIP code _____

This advance directive belongs to: (please print your name on this line) **Date of Birth**

— OFFICIAL USE ONLY —

Step 4: Sign the form - Notary public signature, if needed.

Take this form to a notary public **ONLY** if two witnesses have not signed. The notary public will require that you have photo ID, such as a driver's license or passport, with you.

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

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.

State of California

County of _____

On _____ (Date) before me, _____ (Name and title of officer)

personally appeared _____ (Name(s) of signer(s)),

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) (Notary Seal)

For California skilled nursing facility 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.

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."

Signature _____ Date _____

Print name _____

Street address _____ City _____ State _____ ZIP Code _____

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Providence St. Joseph Health

Step 5: Submit a copy of your completed advance directive.

Once you have signed your advance directive and it has been witnessed and/or notarized, keep the original and make copies of pages 1-9 to send to your:

- Health care representative
- Family
- Friends
- Medical providers
- Hospital

Options for returning your completed advance directive:

1. Return a **COPY** to your preferred Providence St. Joseph Health doctor or hospital at your next visit.
2. Return a **COPY** by using the self-addressed stamped envelope (if available).
3. Return by fax or email (if available) to your Providence St. Joseph Health hospital:

Mission Hospital, Laguna Beach
Mission Hospital, Mission Viejo
St. Joseph Hospital Orange
St. Jude Medical Center
St. Mary Medical Center
Petaluma Valley Hospital
Queen of the Valley Medical Center
Redwood Memorial Hospital
Santa Rosa Memorial Hospital
St. Joseph Hospital, Eureka
Fax to 714-771-8965

or

Email to SJMROI@stjoe.org
(Subject: Advance Directive)

Providence Holy Cross Medical Center
Providence Saint Joseph Medical Center (Burbank)
Providence Saint John's Health Center
Providence Little Company of Mary Medical Center Torrance
Providence Little Company of Mary Medical Center San Pedro
Fax to 310-303-5469

Providence Tarzana Medical Center
Fax to 818-708-5368

For hospitals not listed, please contact your hospital for the correct fax number.

If you have any questions related to completing or returning your advance directive, please contact us at:

Providence.org/InstituteForHumanCaring
424-212-5444

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