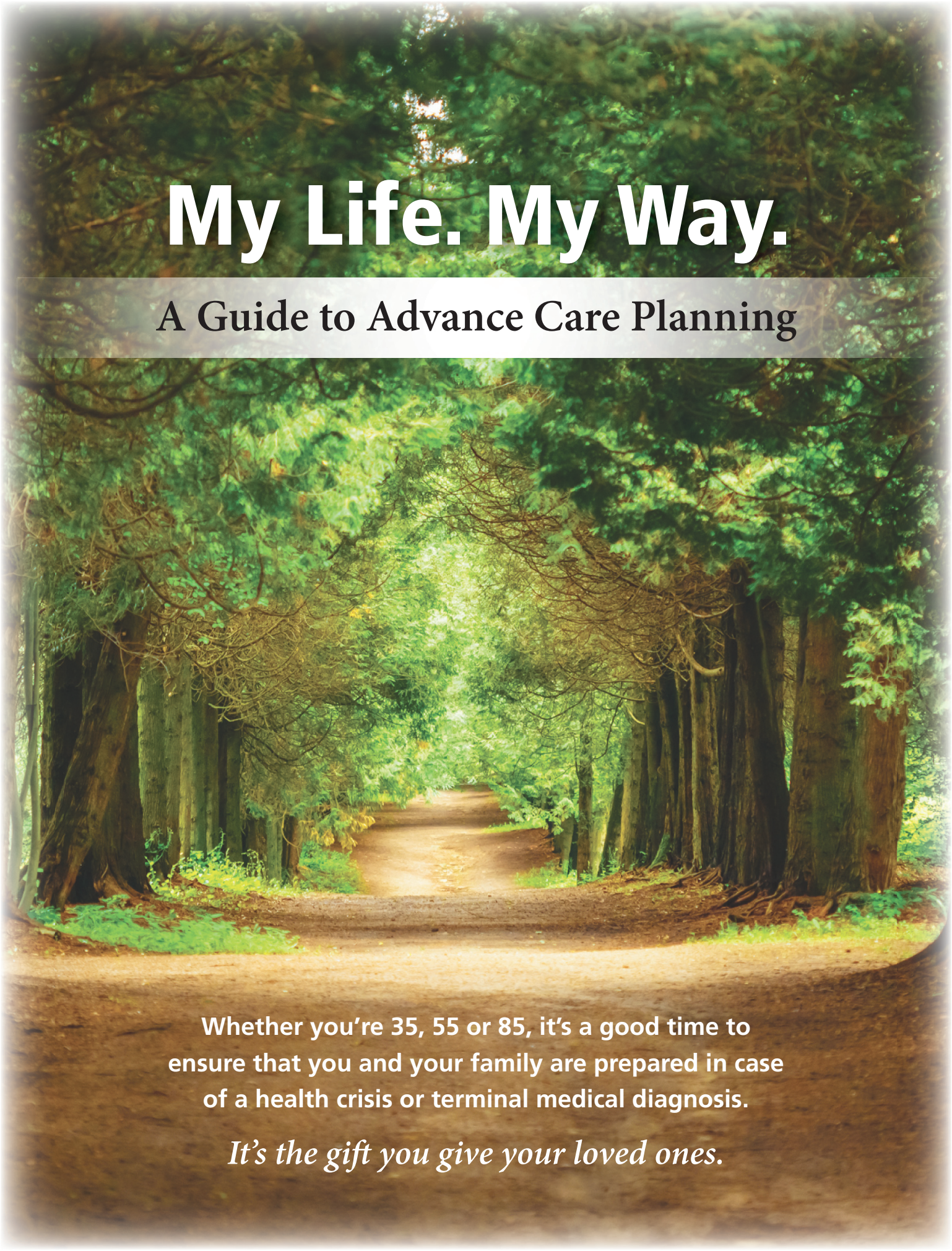

My Life. My Way.

A Guide to Advance Care Planning

Whether you're 35, 55 or 85, it's a good time to ensure that you and your family are prepared in case of a health crisis or terminal medical diagnosis.

It's the gift you give your loved ones.

A GUIDE TO ADVANCE CARE PLANNING

Every day we make dozens of choices for ourselves. Our friends and family learn these choices over time, remembering everything from our favorite colors to what drink to order for us at dinner. Yet when it comes to some of the most important choices we can make – choices about what we would want for our health care if we could not speak for ourselves – few of our friends and family can say for sure what our wishes are.

Deciding the kind of health care you want at the end of your life is called Advance Care Planning, and it's the greatest gift that you can give to your loved ones.

Advance care planning is:

- Learning about possible decisions you may face during a health crisis or illness
- Making choices in light of what is important to you
- Talking about your decisions with loved ones and doctors
- Writing down your plans so they will be ready if needed

The goal of Advance Care Planning is for you to live well in a way that is meaningful to you, for as long as you live.

Most people say they would prefer to die at home, yet only about one-third of adults have an advance directive expressing their wishes for end-of-life care.

(Pew 20016, AARP 2008)

Why Plan Now?

If you become unable to make your own decisions, and your wishes are not formally recorded, your physician will consult someone close to you about your care. They will rely on this person to guess what your wishes would be. Don't let a guess guide your health care! These questions are best considered, decided, and communicated to others in advance, long before there is a health crisis or illness.

FREQUENTLY ASKED QUESTIONS

Q: What is Advance Care Planning?

A: Advance Care Planning is making formal plans for the kind of health care you would want at the end of your life. It means knowing your treatment options and your values, talking with your loved ones, and recording your wishes.

Q: What is an Advance Directive?

A: Advance Directives are legal documents that formally record your future healthcare wishes and appoint a person to make healthcare decisions if you are not able to speak for yourself.

Q: Why bother with an Advance Directive if I just want my family to make the necessary decisions for me?

A: To save those you love from the stress of making these decisions for you in a crisis. You can give your family specific instructions on your medical decisions, which will save them the stress of guessing. First, you can designate the specific person (or persons) you trust to carry out your wishes — your spouse, sibling, child, etc. In fact, this person does not have to be a family member at all.

Second, you can make your views known on a variety of circumstances. For example, your family may have no idea what you think about being on a breathing machine. Recording your wishes is a gift you give the loved ones who are faced with making decisions about your care. Remember, the Advance Directive is used in the case that you are unable to express your own wishes.

Q: What happens if I do not complete my own Advance Directive?

A: There is not a simple answer to this question. In general, physicians consult with families when the person cannot make decisions. You have undoubtedly seen terrible stories in the news where one family member is battling another over their loved one's medical treatments (or lack of treatments); you may have seen or experienced a conflict like it firsthand. **If you cannot speak for yourself, the best way to ensure your healthcare wishes will be carried out is to record them in a set of Advance Directives.**

YOUR VALUES, VIEWS AND BELIEFS

Your values, views and beliefs are important guides in making choices about your life and your health care. Answering the questions below will help you begin the process of creating your own Advance Care Plan.

What is Important to Me?

Check any that apply:

- ❑ Being able to recognize and communicate with family and friends
- ❑ Thinking well enough to make everyday decisions
- ❑ Being conscious and aware of what is happening around you
- ❑ Being able to care for yourself independently (bathing, dressing, feeding)
- ❑ Being able to move about
- ❑ Engaging in favorite activities, like listening to music, watching TV, reading, etc.
- ❑ Being present physically, as long as possible, regardless of my abilities or needs

Other(s)

Would you feel that life would still be worth living if you could not enjoy most or all of these things? Why or why not?

_____

_____

_____

Thinking about Possible Healthcare Choices

1. If you were unable to make healthcare decisions for yourself, who would you like to make decisions for you?

_____

_____

2. If you found out you were going to die soon, what things would you want to take care of first? (i.e. Deal with a business or financial concern, handle a legal matter, mend a friendship, etc.)

_____

_____

3. Do you have religious or spiritual ways to prepare for the end of life? If so, what are they?

_____

_____

4. Are there health problems that you think would be worse than death, such as living with great pain, total physical dependency, or not being able to recognize or communicate with family or friends? If so, please list those things below.

_____

_____

5. If you were dying, which of the following approaches to treatment would you prefer? You may choose more than one. (If you choose more than one, please show your order of preference with 1 being the most important.)

___Your main wish would be for care, including hospice care, that allows you to be comfortable, peaceful, and free from pain.

___You would want to go to the hospital for some treatment, if needed for comfort, but you would not want to be connected to life support machines.

___If it were unclear whether a trial of life support treatment would improve your chances of living, you would like to have a brief period of treatment at the hospital but would like the treatment stopped if you did not improve.

___You would like life support treatments to prolong your life as long as possible, even if those treatments make you uncomfortable.

___You would like to donate organs or tissue and would like life support treatments if needed for organ donation.

Additionally, put your own ideas into words here: _____

_____

_____

6. If you were dying and became unable to eat, which of the following treatments do you think you would want?

❑ Tube inserted into your stomach, nose, or mouth ❑ You would not want a feeding tube

PLANNING FOR COMFORT CARE

In addition to the legal documents, your Advance Care Plan can include anything that you would find comforting during a health crisis or at the end of life. To a healthcare provider, the term "comfort care" means not only relieving pain and symptoms but caring for your physical, emotional, social and spiritual needs. **Answer the following questions to help your loved ones understand what you need to be comfortable.**

Palliative Care: If I have a serious illness, I would like to receive Palliative Care if I am eligible, and it is available. ❑ Yes ❑ No

Hospice Care: If I have been given a terminal diagnosis and have selected not to seek curative treatments, I would like to have care provided under the guidance of a Hospice agency.
❑ Yes ❑ No

Medication: Check the box next to one of the answers below.

❑ I prefer that enough pain medication be given to me to keep me comfortable, even if this means I am not fully aware of what is going on.

❑ I prefer that I be medicated for pain but also want to be aware of my surroundings and what is going on. I understand this may mean my pain control may not be complete. (Again, this applies when I cannot speak for myself.)

Special People: Record the names of special people or pets whose presence would comfort you.

Family members: _____

Special people and/or pets: _____

Members of my faith community: _____

Someone to be with me at the time of my death if possible : _____

Environment: Where would you be most comfortable?

❑ I would like to be at home if possible.

❑ If possible, please take me outdoors.

❑ I would like to be at the hospital. (Which?) _____

❑ I would like to be at a healthcare facility. (Which?) _____

❑ Other: _____

HANDLING YOUR COMPLETED ADVANCE CARE DIRECTIVE

Sharing & Storing Your Documents

Make several photocopies of your completed Advance Directive, Estate Planning documents, and any worksheets from this document that will help express your wishes. Keep the original documents in a safe but easily accessible, place and tell others where you put them; you can note on the photocopies the location(s) where the originals are kept.

Do not keep your Advance Directives in a safe deposit box. In a time of crisis, other people may need quick access to them.

Give photocopies of your documents to everyone who may need them:

- ❑ Your Healthcare Power of Attorney and alternatives
- ❑ Your primary physician and specialists
- ❑ Other family members or friends
- ❑ Your hospital of choice, to keep on file

If you have surgery or are being admitted to a hospital, bring a copy with you and ask for it to be placed in your medical record.

73% of people surveyed said that not being able to communicate their wishes would be worse than dying.

Source: AARP End of Life Survey, 2003

Reviewing and Updating Your Directives

Ideally, your Advance Directive Plan should be reviewed every few years or after a major life event. The American Bar Association uses the "Five D's" to help remember when you should re-examine your healthcare wishes:

- ❑ **Decade** – When you start each new decade of your life.
- ❑ **Death** – Whenever you experience the death of a loved one.
- ❑ **Divorce** – When you experience a divorce or other major family change.
- ❑ **Diagnosis** – When you are diagnosed with a serious health condition.
- ❑ **Decline** – When you experience a significant decline or deterioration of an existing health condition, especially when it diminishes your ability to live independently.

Advance Directives save your loved ones from stressing and guessing your wishes during a crisis… It may be the most important GIFT you ever give.

CALIFORNIA ADVANCE HEALTHCARE 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 healthcare decisions for you if you are too sick to make them yourself.
- **PART 2: Indicate your own healthcare 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 to make it legal.**
  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.**
Two witnesses need to sign on Page 14, or a Notary Public should sign on Page 14.

Your Name: _____

If you only want to name a medical decision maker, go to Part 1 on Page 10.
If you only want to make your own healthcare choices, go to Part 2 on Page 11.
If you want both, then fill out Part 1 and Part 2.

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 your 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 healthcare choices that are not on this form?

- Write your choices on Page 10.

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 healthcare 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 him/her.
- 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 or a judge to make decisions for you. This person may not know what you want.

The kinds of decisions your medical decision maker can make:

She or he will be able to choose:

- doctors, nurses, social workers, caregivers, hospice care, hospitals, clinics, nursing homes.
- medications, tests, or treatments.
- what kind of personal care you get, such as where you live.
- who can look at your medical information.
- what happens to your body and organs after you die.

CHOOSE YOUR HEALTH CARE AGENT

More 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 into your throat to your stomach. It can also be placed surgically.
- **Blood Transfusions** — To put blood into your veins.
- **Surgery**
- **Medicines**

End of Life Care — if you might die soon, your medical decision maker can:

- decide if you will receive hospice care.
- call in a spiritual leader.
- decide if you die at home or in the hospital.
- decide where you should be buried or cremated.

Write down any decisions you do not want your medical decision maker to make:

_____

Write down any medical wishes that are not on this form:

_____

Talk to your medical decision maker about this form and your choices.

Your Medical Decision Maker

I want this person to make my medical decision if I cannot make my own:

_____

FIRST NAME | LAST NAME | RELATIONSHIP

_____

HOME PHONE | WORK PHONE | CELL PHONE

_____

STREET ADDRESS, CITY, STATE, ZIP CODE

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

_____

FIRST NAME | LAST NAME | RELATIONSHIP

_____

HOME PHONE | WORK PHONE | CELL PHONE

_____

STREET ADDRESS, CITY, STATE, ZIP CODE

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 doctor/s 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 doctor/s 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 decision, even if the doctors recommend it.

To make your own healthcare choices, go to Part 2.
If you are done, you must sign this form on Page 13.

PART 2

MAKE YOUR OWN HEALTHCARE CHOICES

Write down your choices so those who care for you will not have to guess. Think about what makes your life worth living. Put an X next to all the sentences you most agree with.

My life is only worth living if I can:

❑ talk to family or friends
❑ wake up from a coma
❑ feed, bathe, or take care of myself
❑ be free from pain
❑ live without being hooked up to machines
❑ my life is always worth living no matter how sick I am
❑ I am not sure

If I am dying, it is important for me to be:

❑ receiving hospice care
❑ 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 religion or spiritual beliefs?

_____

_____

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain. Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, surgeries or medicine.

Please read this whole page before you make your choice. Put an X next to the ONE choice 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 to stop.
- ❑ **I do not want life support treatments,** and I want to focus on being comfortable with care provided by a hospice agency. I prefer to have a natural death.
- ❑ I want my **medical decision maker** to decide for me.
- ❑ I am not sure.

Go to page 10 if you want to write down medical wishes that are not on this form.

Your doctors may ask about organ donation and autopsy. Please indicate 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 ❑ eyes ❑ skin ❑ heart ❑ lungs ❑ other: _____
  ❑ 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 treated after you die?

Do you have funeral or burial wishes? _____

What other wishes are important to you? _____

_____

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 or a notary public witness you signing the form

_____ / ____ / ____

SIGN YOUR NAME DATE

_____

PRINT YOUR FIRST NAME PRINT YOUR LAST NAME

_____

STREET ADDRESS, CITY, STATE, ZIP CODE

Witnesses

You must have two witnesses or a notary public sign the form

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 healthcare provider.
- work for your healthcare provider.
- work at the place that you live (if you live in a nursing home, go to page 15).

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 14.

- A notary public's job is to make sure that it is you who is signing the form.

Witnesses need to sign their names on the next page.

By signing, I promise that (NAME)_____ signed this form while I watched. 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 healthcare provider.
- I do not work for his/her healthcare 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

_____

STREET ADDRESS, CITY, STATE, ZIP CODE

Witness #2:

_____ / / _____

SIGN YOUR NAME DATE

_____

PRINT YOUR FIRST NAME PRINT YOUR LAST NAME

_____

STREET ADDRESS, CITY, STATE, ZIP CODE

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk to 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.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California: 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.

County of _____

On _____ before me, _____ personally

DATE HERE INSERT NAME & TITLE OF THE OFFICER

appeared _____

NAME OF SIGNER

_____,

who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature is on the instrument the person, or the entity upon behalf of which the person 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 of Notary Public: ______________________________

- -

Description of Attached Document

Title or Type of document: ______________________________ Right Thumbprint

Date: ____________________ Number of Pages: __________ of signer (notary seal)

Capacity Claimed by Signer

Signer's name: ______________________________

❑ Individual ❑ Guardian or conservator ❑ Other: ____________________

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.

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

____

STREET ADDRESS, CITY, STATE, ZIP CODE

Your Life, Your Way.

It's About How You Want to Live Each Moment to its Fullest

Call Hospice First: 707-263-6222

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Case Management

Grief Counseling and Emotional Support

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Our Mission

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