UC DAVIS HEALTH

Advance Health Care Directive

Use this form to have a say in your medical care if you become unable to make your own decisions. The form has three steps:

Step 1: Name your health care agent

Step 2: Write down your health care instructions

Step 3: Sign the form to make it legal

This is the Advance Health Care Directive of:

Name _____

Date of Birth _____

When this form is complete:

☐ Share copies with your medical team, health care agent, and family.

☐ Keep the original in a safe place.

☐ Talk with your health care agent and loved ones about what matters most to you in your health care.

Remember:

☐ You have the right to revoke or change this Advance Health Care Directive.

☐ You can replace this Advance Health Care Directive by completing a new one. If needed, the choices from your most recent Advance Health Care Directive would be followed.

Step 1: Name Your Health Care Agent

Your health care agent would help make health care decisions if you were unable to make them for yourself.

Your health care agent should be someone who:

- Knows you well and can help your medical team understand your health care priorities
- You trust to follow your wishes and do what is best for you
- Can be reached in an emergency
- Is at least 18 years old

Your health care agent cannot be a member of your medical team.

If you become unable to make decisions for yourself, your health care agent can help choose:

- Your hospital, clinic, nursing home or residence, medical team, and in-home caregivers
- Medications, tests, and treatments
- Who can see your medical records
- Whether to start or stop life support treatments like CPR (cardiopulmonary resuscitation), a mechanical ventilator (breathing machine), dialysis, artificial feeding, blood transfusions, and more
- What is done with your body and organs after you die

My health care agent

I want this person to be my health care agent, to help make my health care decisions if I become unable to make them for myself:

Name _____

Relationship _____ Phone _____

(Optional) **My alternate health care agent**

If the first person cannot do it, I want this person to be my health care agent, to help make my health care decisions if I become unable to make them for myself:

Name _____

Relationship _____ Phone _____

(Optional) **My second alternate health care agent**

If the first and second people cannot do it, I want this person to be my health care agent, to help make my health care decisions if I become unable to make them for myself:

Name _____

Relationship _____ Phone _____

(Optional) **Add any comments about your choice of health care agent:**

_____

_____

_____

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My health care agent's authority will go into effect if a physician determines that I've lost the ability to make informed medical decisions for myself.

Step 2: Write Down Your Health Care Instructions

If you become critically ill or injured, and you are unable to make your own decisions, **Step 2** will help make sure you have a say about important health care decisions.

Specific instructions: life support treatments
Life support treatments are medical treatments that try to keep your body alive when it would otherwise die. They can include cardiopulmonary resuscitation (CPR), a mechanical ventilator (breathing machine), dialysis, feeding tubes, blood transfusions, and more.

If I were critically ill or injured, and dying, I would want to:
(Put your initials by the one choice you agree with most).

_____ Try all life support treatments that might keep me alive. I would want life support treatments to continue even if there was little hope of getting better.

_____ Have a trial of life support treatments that might keep me alive. But I would want to STOP life support treatments if they did not help me get better or I could not live without them. At that point, I would want to allow a natural death with help to ease pain or suffering.

_____ Allow a natural death, with help to ease pain or suffering. I would not want life support treatments.

_____ I am not sure.

(Optional) **Any other comments or instructions:**

Step 3: Sign the Form to Make It Legal

To make this a legal document, you must sign the form in front of two witnesses or a Notary Public. (If you reside in a nursing home, the patient advocate or ombudsman must also sign).

You Fill Out This Part

Your signature _____ Date _____

Print your name _____

Address _____

Phone _____

Witnesses Fill Out This Part

(This is only needed if a Notary has not notarized the form).

I confirm that I know the person who signed this advance health care directive; this person signed or acknowledged signing the form in my presence; and the person appears to be of sound mind and under no duress. I also confirm that I am 18 years or older; I am not the health care agent designated in this form; I am not the health care provider; and I am not an employee of the health care provider or any health care facility where this person resides.

Witness #1

Signature _____ Date _____

Print name _____

Address _____

Witness #2

Signature _____ Date _____

Print name _____

Address _____

One witness must also sign this statement:
I also confirm that I am not related to the person who signed this form by blood, marriage, or adoption. I will not benefit financially (receive money or property) after this person dies.

Signature _____

Notary Public Fills Out This Part

*(*This is only needed if two witnesses have not signed the form).

State of California

County of _____

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.

On _____ before me, _____ ,

personally appeared _____ ,

who proved to me on the basis of satisfactory evidence to be the person(s) who 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 _____

(Notary Seal)

Patient Advocate or Ombudsman Fills Out This Part

(This is only needed if you are a patient in a skilled nursing facility).

I declare under PENALTY OF PERJURY under the laws of the State 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.

Date _____ Time _____

Signature _____

Print name _____

Address _____

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