

# **ADVANCE HEALTH CARE DIRECTIVE OF:**

\_\_\_\_\_  
(name)

## **ATTENTION HEALTH CARE PROVIDERS:**

This document is an Advance Health Care Directive – a legally binding document under state and federal law, which dictates the health care treatment that may be given to an individual who lacks capacity to make health care decisions. Cal. Probate Code Section 4600 *et seq.*; 42 Code of Federal Regulations Sections 431.20, 489.100, 489.102, and 489.104.

This Advance Health Care Directive contains a Power of Attorney for Health Care and/or Individual Health Care Instructions. If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

## **SPECIFIC DUTIES OF HEALTH CARE PROVIDERS INCLUDE:**

- ❖ Maintaining this document in the patient's health records. Cal. Probate Code Section 4731(a).
- ❖ Notifying the designated agent that the patient lacks or has recovered capacity. Cal. Probate Code Section 4732.
- ❖ Providing the designated agent access to the patient's health records. Cal. Probate Code Section 4678.

## **DURATION AND REVOCABILITY:**

Advance Health Care Directives do not expire unless a specific expiration date is stated in the document. Cal. Probate Code Section 4686.

A patient having capacity may revoke the designation of an agent by a signed writing or by personally informing the health care provider, and may revoke any and all other parts of an Advance Health Care Directive in any manner that communicates an intent to revoke. Cal. Probate Code Section 4695.

Be aware that an agent is not authorized to make a health care decision if the patient objects to the decision. Before implementing a health care decision made for a patient, the health care provider must promptly inform the patient about the decision and the identity of the person making the decision. Cal. Probate Code Sections 4689, 4730.

In addition, this document states that no individual mental or physical health care instruction may be carried out against the wishes of the patient. If the patient objects to his or her agent's health care decision or to the implementation of an individual mental or physical health care instruction contained in this document, the matter concerning that particular procedure shall be governed by the law that would apply if there were no Power of Attorney for Health Care or Individual Health Care Instruction regarding that procedure. Cal. Probate Code Section 4689.

#### **LIABILITY AND IMMUNITY:**

Failure to follow an Advance Health Care Directive may result in liability for damages specified in California law or actual damages, whichever is greater, plus attorney's fees. Cal. Probate Code Section 4742. Violators may also be liable for negligence, malpractice and battery claims.

Health care providers are not subject to civil or criminal liability or to discipline for unprofessional conduct for compliance with Advance Health Care Directives. Cal. Probate Code Section 4740.

#### **DISCRIMINATION PROHIBITED:**

Health care providers and health care insurers may not require or prohibit the execution or revocation of an Advance Health Care Directive as a condition for providing health care, admission to a facility, or furnishing insurance. Cal. Probate Code Section 4677.

## **ADVANCE HEALTH CARE DIRECTIVE: Explanation**

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

*Part I* of this form is a power of attorney for health care. Part I lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

- (e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

*Part II(a)* of this form lets you give specific instructions about any aspect of your mental health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision of mental health care, and at the end of Part II(a), space is provided for you to add any additional choices about mental health care which are not covered elsewhere.

*Part II(b)* of this form lets you give specific instructions about any aspect of your physical health care, including end-of-life decisions and instructions about anatomical gifts, autopsy, and disposition of your remains.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

If you or your agent have difficulty enforcing this advance health care directive, contact your county patient's rights advocate or Disability Rights California (1-800-776-5746).

**Advance Health Care Directive of \_\_\_\_\_**

(Your name)

**Instructions Included in My Directive**

*Put a check mark in the left-hand column for each section you have completed.*

#	<b>PART I Appointment of an Agent for Healthcare</b>
1	Designation of Health Care Agent Designation of Alternate Health Care Agent
2	Authority Granted to My Agent
3	My choice as to a Court Appointed Conservator
#	<b>PART II(a) Statement of Individual Mental Health Care Instructions</b>
4	Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?
5	My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being
6	My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:
7	My Choices about primary Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable
8	My Choices Regarding Methods for Avoiding Emergency Situations
9	My Choices Regarding Emergency Interventions
9(a)	My Choices Regarding <b>Routine</b> Medications for Psychiatric Treatment
9(b)	My Choices Regarding <b>Emergency</b> Psychiatric Medication
10	My Choices Regarding Electroconvulsive Therapy
11	The Following People Are to be Prohibited from Visiting Me
12	Other Instructions About Mental Health Care

#	<b>PART II(b)</b> <b>Individual Physical Health Care Instructions</b>
13	My Primary Physician who is to Have Primary Responsibility for my Physical Health Care is:
14	Statement of Desires, Special Provisions and Limitations
15	My Choices Regarding Experimental Studies and Drug Trials
16	My Instructions Regarding Life Sustaining Treatment
17	My Choices Regarding Contribution of Anatomical Gift
18	My Instructions Regarding Autopsy
19	Choices Regarding Disposition of My Remains

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

**PART I  
APPOINTMENT OF AN AGENT FOR HEALTH CARE**

**\*\*MAKE SURE YOU GIVE YOUR AGENT  
A COPY OF ALL SECTIONS OF THIS DOCUMENT\*\***

If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

**STATEMENT OF INTENT TO APPOINT AN AGENT:**

I, (your name) \_\_\_\_\_, being of sound mind, authorize a health care agent to make certain decisions of my behalf regarding my health treatment when I am incompetent to do so unless I mark this box , in which case my agent's authority to make health care decisions for me takes effect immediately. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

**1. Designation of Health Care Agent**

A. I hereby designate and appoint the following person as my agent to make health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Designation of Alternate Health Care Agent**

If the person named above is unavailable, unable or unwilling to serve as my agent, I hereby appoint and desire immediate notification of my alternative agent as follows:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



**2. Authority Granted to My Agent**

If I become incapable of giving informed consent to health care treatment, or if I marked the box under "Statement of Intent to Appoint an Agent" causing my agent's authority to make decisions for me to immediately become effective, I hereby grant to my agent full power and authority to make health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive EXCEPT as I state here. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. My Choice as to a Court-Appointed Conservator**

In the event a court decides to appoint a conservator who will make decisions regarding my health treatment, I desire the following person to be appointed:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

The appointment of a conservator or other decision maker shall not give the conservator or decision maker the power to revoke, suspend, or terminate my individual health care instructions or the powers of my agent.

**\*\*MAKE SURE YOU GIVE YOUR AGENT AND ALTERNATE AGENT  
A COPY OF ALL SECTIONS OF THIS DOCUMENT\*\***

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

**PART II(a)  
STATEMENT OF INDIVIDUAL  
MENTAL HEALTH CARE INSTRUCTIONS**

*In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials before the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.*

**NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES.**

**4. Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?** *Be sure to include the agent and any alternate agent you designate in your Durable Power of Attorney, if you have one.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pager: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**5. My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being**

\_\_\_\_\_ A. In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at the following programs/facilities instead of psychiatric hospitalization.

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_ B. In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_ C. I do not wish to be admitted to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

Facility's Name: \_\_\_\_\_

Reason: \_\_\_\_\_

**6. My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:**

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Pager \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**7. My Choices about the Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable**

Put your initials before the letter and complete if you wish either or both paragraphs to apply.

\_\_\_\_\_ A. My choice of treating physician if the above physician is unavailable is:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

OR if neither is available

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

OR if none of the above is available

Dr. \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ B. I do not wish to be treated by the following, for the reasons stated:

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

## 8. My Choices Regarding Methods for Avoiding Emergency Situations

If during my admission or commitment to a mental health treatment facility it is determined that I am engaging in behavior that **may** make emergency intervention necessary, I prefer the following choices to help me regain control:

*Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If your choice is not listed, write it in after "other" and give it a number as well.*

- Provide a quiet private place
- Have a staff member of my choice talk with me one-on-one
- Allow me to engage in physical exercise
- Offer me recreational activities
- Assist me with telephoning a friend or family member
- Offer me the opportunity to take a warm bath
- Offer me medication
- Offer me a cigarette
- Allow me to go outside
- Provide me with materials to journal or do artwork
- Offer me assistance with breathing or calming exercises
- Provide me with a radio to listen to
- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 9. My Choices Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made as follows. I prefer these interventions in the following order:

*Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well. If you do not want a listed intervention ever used, cross it out and explain why under "Reasons for my choices."*

	Reasons for my choices
<input type="checkbox"/> Seclusion	_____
<input type="checkbox"/> Physical restraints	_____
<input type="checkbox"/> Seclusion and physical restraint (combined)	_____
<input type="checkbox"/> Medication by injection	_____
<input type="checkbox"/> Medication in pill form	_____
<input type="checkbox"/> Liquid medication	_____
<input type="checkbox"/> During seclusion and/or restraint, I prefer to be checked by <b>female</b> staff	_____
<input type="checkbox"/> During seclusion and/or restraint, I prefer to be checked by <b>male</b> staff	_____
<input type="checkbox"/> Other: _____	_____
_____	_____
_____	_____

*See Section 9(b) for choices regarding emergency medication*

I expect the choice of medication in an emergency situation to reflect any choices I have expressed in this section and in Section 9(b). **The choices I express in this section and Section 9(b) regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.**

**9(a). My Choice Regarding *Routine* Medications for Psychiatric Treatment**

*In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.*

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

\_\_\_\_ A. I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

\_\_\_\_ B. I consent to and authorize my agent to consent to the administration of:

<b>Medication Name or Medication Type</b>	<b>Not to exceed the following dosage/day</b>	<b>OR</b>	<b>In such dosage(s) as determined by</b>
_____	_____		Dr. _____
_____	_____		Or if unavailable, then by
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		
_____	_____		

\_\_\_\_ C. I consent to the medications deemed appropriate by Dr. \_\_\_\_\_ ,  
whose address and phone number are: \_\_\_\_\_  
\_\_\_\_\_



**9(a) Continued**

\_\_\_\_ D. I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents:

Name of Drug	Reason for Refusal
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_ E. I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

\_\_\_\_ F. I am concerned about the side effects of medications and do **not** consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at 1% or greater level of incidence (*check all that apply*).

- |   |   |
|---|---|
| <input type="checkbox"/> Tardive dyskinesia       | <input type="checkbox"/> Tremors                        |
| <input type="checkbox"/> Loss of Sensation        | <input type="checkbox"/> Nausea/vomiting                |
| <input type="checkbox"/> Motor Restlessness       | <input type="checkbox"/> Neuroleptic Malignant Syndrome |
| <input type="checkbox"/> Seizures                 | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Muscle/skeletal rigidity | _____   |

\_\_\_\_ G. I have the following other choices about psychiatric medications:

\_\_\_\_\_  
\_\_\_\_\_

**9(b) My Choices Regarding *Emergency* Psychiatric Medication**

If during my admission or commitment to a mental health facility, it is determined that I am engaging in behavior that requires emergency psychiatric medication, I prefer the following medication:

Medication Name or Medication Type	Not to exceed the following dosage/day	OR In such dosage(s) as determined by
_____	_____	Dr. _____
_____	_____	Or if unavailable, then by
_____	_____	Dr. _____
_____	_____	
_____	_____	
_____	_____	
_____	_____	

**The choices expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.**

**10. My Choices Regarding Electroconvulsive Therapy**

\_\_\_\_ A. I **do not** consent to administration of electroconvulsive therapy.

B. Under California law, this Directive **cannot** be used to consent for electroconvulsive therapy. However, if I am administered electroconvulsive therapy, I have the following choices:

- I will be administered no more than the following number of treatments \_\_\_\_ .
- I will be administered the number of treatments deemed appropriate by Dr. \_\_\_\_\_, whose phone number and address is: \_\_\_\_\_ .

**11. The Following People Are to be Prohibited from Visiting Me:**

**Name**

**Relationship**

_____	_____
_____	_____
_____	_____
_____	_____

**12. Other Instructions About Mental Health Care**

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)*

Advance Health Care Directive of \_\_\_\_\_  
(Your name)

**PART II(b)**  
**INDIVIDUAL PHYSICAL HEALTH CARE INSTRUCTIONS**

**NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES**

**13. My Primary Physician who is to have primary responsibility for my physical health care is:**

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Pager \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

OR if the above physician is unavailable, then I request:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

OR if neither of the above is available, then I request:

Dr. \_\_\_\_\_ Phone \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

I specifically do not want to be treated by the following physicians:

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_

OR

Dr. \_\_\_\_\_ Reason: \_\_\_\_\_



## 15. My Choices Regarding Experimental Studies and Drug Trials

I **will not** participate in experimental studies or drug trials.

Under recent changes to California law, a health care agent, if one has been appointed, a conservator, a family member, or domestic partner may consent to participation in a medical experiment on behalf of a person who is unable to consent under very specific circumstances. See Health and Safety Code, section 24178 for a list of these specific circumstances.

Complete this section **only** if you do not consent to participation in medical experiments under any circumstances.

**16. My Instructions Regarding Life Sustaining Treatment**

\_\_\_\_ A. I **do not** want my life to be prolonged and I **do not** want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. I want the relief of suffering and the quality as well as the possible extension of my life considered in making decisions concerning life-sustaining treatment.

**OR**

\_\_\_\_ B. I want my life to be prolonged and I want life sustaining treatment to be provided **unless I am in a coma or vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I **do not** want life-sustaining treatment to be provided or continued.

**OR**

\_\_\_\_ C. I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of procedures.

**AND/OR**

\_\_\_\_ D. I specifically express the following desires concerning life-sustaining treatment.

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### 17. My Choices Regarding Contribution of Anatomical Gift

*If either statement reflects your desires, sign the line next to the statement. You do not have to sign either statement. If you do not wish to sign either statement, your agent (if you have one) and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.*

I **do** want to make a gift under the Uniform Anatomical Gift Act, effective upon my death, of:

Any needed organs or parts; or

The parts or organs listed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

(Signature)

I **do not** want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to do so.

\_\_\_\_\_

(Signature)

### 18. My Instructions Regarding Autopsy

*If either statement reflects your desires, sign the line next to the statement. You **do not** have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to authorize an autopsy.*

I **do** authorize an examination of my body after death to determine the cause of my death.

I **do not** authorize an examination of my body after death to determine the cause of my death.

\_\_\_\_\_

(Signature)

\_\_\_\_\_

(Signature)



## 19. Choices Regarding Disposition of my Remains

If either statement reflects your desires, sign the line beneath the statement. You do not have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to direct the disposition of your remains.

I **do** authorize

\_\_\_\_\_ (name) \_\_\_\_\_ (phone)

\_\_\_\_\_ (address/city/state/zip)

to direct the disposition of my remains by the following method:

Burial

Cremation

\_\_\_\_\_ (signature)

**OR**

I have described the way I want my remains disposed of in:

A written contract for funeral services with:

\_\_\_\_\_ (name and phone of mortuary/cemetery)

\_\_\_\_\_ (address/city/state/zip)

My will.

Other: \_\_\_\_\_

\_\_\_\_\_ (signature)

**By signing below, I am executing this advance directive for health care and, by so doing, am revoking any prior durable power of attorney for health care.**

**EFFECT OF COPY:** A copy of this form has the same effect as the original.

**SIGNATURE:** Sign and date the form here in the presence of your witnesses/notary.

\_\_\_\_\_  
*(date)*

\_\_\_\_\_  
*(signature)*

\_\_\_\_\_  
*(address)*

\_\_\_\_\_  
*(print your name)*

\_\_\_\_\_  
*(city) (state)*

**STATEMENT OF WITNESSES:** I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

Second Witness

\_\_\_\_\_  
*(print name)*

\_\_\_\_\_  
*(print name)*

\_\_\_\_\_  
*(address)*

\_\_\_\_\_  
*(address)*

\_\_\_\_\_  
*(city) (state)*

\_\_\_\_\_  
*(city) (state)*

\_\_\_\_\_  
*(signature of witness)*

\_\_\_\_\_  
*(signature of witness)*

\_\_\_\_\_  
*(date)*

\_\_\_\_\_  
*(date)*

**ADDITIONAL STATEMENT OF WITNESSES:** At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California, that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

\_\_\_\_\_  
*(signature of witness)*

\_\_\_\_\_  
*(signature of witness)*

**SPECIAL WITNESS REQUIREMENT:** The following statement is required only if you are a patient in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

**STATEMENT OF 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.

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(city) (state)

**ACKNOWLEDGEMENT OF NOTARY PUBLIC**

State of California)

County of \_\_\_\_\_ )

On \_\_\_\_\_, before me, \_\_\_\_\_ (here insert name and title of the officer), personally appeared \_\_\_\_\_ personally known to me (or 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.

WITNESS my hand and official seal.

Signature: \_\_\_\_\_ (Seal)

**This document is valid only if signed by two witnesses OR acknowledged before a notary public.**