

# Your Right to Make Health Care Decisions



**Stanford**  
HEALTH CARE  
STANFORD MEDICINE

**ValleyCare**

# Advance Care Planning

Stanford Health Care - ValleyCare is committed to helping you exercise your rights in relation to your medical treatment. We hope this information will help increase your control over your medical treatment.

## What is Advance Care Planning?

Advance Care Planning is a patient-centered process of communication with patients and their families about their wishes/treatment preferences so that their goals of health care are honored and implemented. Advance Care Planning is not limited to a single event or a single conversation. It is often accomplished through a series of discussions and health care encounters.

## What is an Advance Health Care Directive?

An Advance Health Care Directive is a document that enables you to: 1) state your health care instructions for any situation; and 2) designate another person to make health care decisions on your behalf should you be unable to do so. It's called "advance" because you prepare it before health care decisions need to be made. It's called a "directive" because it states who will speak on your behalf and what you would want done. In California, the Advance Health Care Directive includes the appointment of an agent and your Health Care instructions.

## Who makes decisions about my medical treatment?

You have the right to decide. Your physicians will give you information and their recommendations concerning your treatment. You can say "yes" to the recommended treatments or procedures you want. You can say "no" to any treatment or procedure you do not want, even when it's a treatment or procedure which might help you to live longer.

## How do I know what I want?

Your physician will tell you about your medical condition. Your physician will also tell you about any treatments, procedures or pain management options recommended for your condition, along with any possible side effects. Your physician must offer you information about any possible side effects of the different treatments or procedures.

More than one treatment option is often available to help patients. Your physician can tell you which treatments are available to you, but the physician cannot choose for you. That choice is yours to make and will depend upon what's important to you.

### When is a good time to prepare an Advance Directive for health care?

Any time is a good time. The ideal time might be when you are well and have the time to think about what you might want or not want should you have a terminal condition. It's also important to have a conversation with the persons you name as your agents so they know what you'd want.

### Can other people help with my decisions?

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. Your family or friends can help you think about the choices you face and how you might want to make your decisions based on your values and wishes.

### May I choose a relative or friend to make health care decisions for me?

Yes, you may choose to have a relative or friend make health care decisions for you. There are several ways you can do that:

- You can tell your physician to list that person as your health care “surrogate” in your medical record for this hospitalization.
- You can name this person as your “agent” in an Advance Health Care Directive.

### What if I become too sick to make my own health care decisions?

If you have named an agent, the physicians will ask that person to make decisions for you. If you haven't named an agent, your physician will ask your closest available relative or friend to help decide what is best for you. Most of the time that works, but sometimes family members or friends don't agree about what to do or don't know what you would want. That's why it is helpful for you to designate an agent who knows what you would want if you cannot speak for yourself.

### Who can make an Advance Health Care Directive?

If you are 18 years or older and of “sound mind,” you can make an Advance Health Care Directive. You do not need a lawyer and you do not need a notary. You can complete the form in this booklet and ask two people to witness your signature. Neither of these people can be one of your designated health care agents. At least one of the witnesses cannot be related to you by blood, marriage, or adoption and cannot be entitled to any part of your estate upon your death.

### Who can I name as my agent?

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made. It is recommended that you have a conversation with this person about your values and wishes so that she or he will really know what you would want. The following persons may not be your agent: your supervising health care provider, an employee of the health facility where you are receiving care, or an employee or operator of community care and residential care facilities where you are receiving care.

### When does my agent begin making my medical decisions?

Usually your health care agent will make decisions only if you lose the ability to make them yourself. If you wish, you can state in your Advance Health Care Directive that you want your agent to begin making decisions immediately.

### What if I don't want to name an agent?

You do not have to designate an agent. You can still write out your wishes in an Advance Health Care Directive. This will give your physicians and your family or friends some idea of what you would want if the time came that you couldn't speak for yourself. You can also discuss your wishes with your doctor and ask your doctor to list those wishes in your medical record.

### Will I still be treated if I don't make an Advance Health Care Directive?

Absolutely. You will still get medical treatment. If you become too sick to make decisions yourself, someone else will have to make them for you.

### What happens when someone else makes decisions about my treatment?

The same rules apply to anyone who makes health care decisions on your behalf — a health care agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your health care instructions in your Advance Health Care Directive. If you have not written anything down, they are required to follow your general wishes about treatment. If your treatment wishes are not known, the agent must try to determine what is in your best interest.

The people providing your health care must follow the decisions of your agent unless a requested treatment is not within recognized medical standards or would be ineffective in your situation. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another health care provider to take over your treatment.

### What if I change my mind?

You can change or cancel your Advance Health Care Directive at any time as long as you can communicate your wishes. To change the name of your agent, you must complete a new Advance Health Care Directive. When you prepare a new Advance Health Care Directive, give or send a copy of the new document to your physicians, hospital and agents.

### What should I do after I have my Advance Health Care Directive signed and witnessed?

If you prepare the document at home, make photocopies of the form for your agent, alternate agents, anyone else of your family or friends who might be involved in your care. Bring a photocopy to your doctor at your next visit so it can be included in your medical record. Make some extra copies so you can take one with you if you are admitted to a hospital, skilled nursing facility or any other health care facility. Keep the original in a place where you can access it easily and you can tell others how to find it as well.

If you prepare the document while at ValleyCare, the staff who assist you will make the needed photocopies and will make sure a copy is sent to Medical Records to be kept on file.

You may also register your Advance Health Care Directive with the California registry.

Please refer to the following site for information: <http://www.sos.ca.gov/ahcdr/>

### How can I get more information about making an Advance Health Care Directive?

When you are admitted, you will be asked if you have an Advance Health Care Directive. If you don't have one, you will be asked if you want to create one. You can also ask your doctor, nurse, social worker, or other health care provider to get more information for you. You can have a lawyer write an Advance Health Care Directive for you or you can complete an Advance Health Care Directive form.

### Are there other ways that I can make my health care wishes known?

For persons with a life-limiting illness, a POLST (Physician Orders for Life-Sustaining Treatment) is a document designed to express a preference for levels of treatment. It includes orders describing CPR, Medical Interventions (intensity of care — ICU, no-ICU, comfort care, etc.) and the use of artificial nutrition. This document is intended to stay with a patient whether an in-patient or an out-patient. It is signed by the patient or the patient's legally recognized decision maker. It is also signed by the patient's physician. It does not replace the Advance Health Care Directive.

Information about the POLST is also available at: <http://www.capolst.org> where you can also download a copy of the form.

# ADVANCE HEALTH CARE DIRECTIVE

## **INSTRUCTIONS**

Part 1 of this form 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 an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

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.***

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**PART 1 – POWER OF ATTORNEY FOR HEALTH CARE**

**DESIGNATION OF AGENT:**

I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: \_\_\_\_\_

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

Telephone: \_\_\_\_\_  
(home phone) (work phone) (cell/pager)

OPTIONAL: If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: \_\_\_\_\_

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

Telephone: \_\_\_\_\_  
(home phone) (work phone) (cell/pager)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: \_\_\_\_\_

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

Telephone: \_\_\_\_\_  
(home phone) (work phone) (cell/pager)

**AGENT’S AUTHORITY:**

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

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

*(Add additional sheets if needed.)*

**WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:**

My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

\_\_\_\_\_  
*(Initial here)*

**OR**

My agent’s authority to make health care decisions for me takes effect immediately.

\_\_\_\_\_  
*(Initial here)*

**AGENT’S OBLIGATION:**

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**AGENT’S POSTDEATH AUTHORITY:**

My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

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

*(Add additional sheets if needed.)*

**NOMINATION OF CONSERVATOR:**

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.



**PART 2 – INSTRUCTIONS FOR HEALTH CARE**

If you fill out this part of the form, you may strike any wording you do not want.

**END OF LIFE DECISIONS:**

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

**Choice Not To Prolong Life:**

\_\_\_\_\_  
(Initial here)

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

**OR**

**Choice To Prolong Life:**

\_\_\_\_\_  
(Initial here)

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

**RELIEF FROM PAIN:**

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

\_\_\_\_\_  
\_\_\_\_\_  
(Add additional sheets if needed.)

**OTHER WISHES:**

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Add additional sheets if needed.)

**PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)**

I. Upon my death:

I give any needed organs, tissues, or parts. \_\_\_\_\_  
(Initial here)

**OR**

I do *not* authorize the donation of any organs, tissues or parts. \_\_\_\_\_  
(Initial here)

**OR**

I give the following organs, tissues, or parts only: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.

My gift is for the following purposes:

Transplant \_\_\_\_\_ Research \_\_\_\_\_  
(Initial here) (Initial here)

Therapy \_\_\_\_\_ Education \_\_\_\_\_  
(Initial here) (Initial here)

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)

2. My donated tissue may be used for applications outside of the United States.

Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)

(Health and Safety Code Section 7158.3)

**PART 4 – PRIMARY PHYSICIAN (OPTIONAL)**

I designate the following physician as my primary physician:

Name of Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

\_\_\_\_\_

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

\_\_\_\_\_

**PART 5 – SIGNATURE**

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

**SIGNATURE:**

Sign and date the form here:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(patient)

Print name: \_\_\_\_\_  
(patient)

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

**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**

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

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

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

**SECOND WITNESS**

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

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

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

**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.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

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 the document.

*YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.*

State of California \_\_\_\_\_ )

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

)

On (date) \_\_\_\_\_ before me, (name and title of the 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: \_\_\_\_\_ [Seal]  
(notary)

**PART 6—SPECIAL WITNESS REQUIREMENT**

If you are a patient in a skilled nursing facility, 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: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(patient advocate or ombudsman)

Print name: \_\_\_\_\_  
(patient advocate or ombudsman)

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