ADVANCE HEALTH CARE DIRECTIVE FORM

Date:

Your Name: Last First Middle initial

Street Address City State Zip

PART 1: INDIVIDUAL INSTRUCTIONS FOR HEALTH CARE

The following statements only apply

- if I am close to death and life support would only postpone the moment of my death **OR**
- if I am in an unconscious state such as an irreversible coma or a persistent vegetative state and it is unlikely that I will ever become conscious **OR**
- if I have brain damage or a brain disease that makes me permanently unable to make and communicate health care decisions about myself.

INITIAL ONLY ONE (1) CHOICE IN EACH SECTION and CROSS OUT ALL THAT DO NOT APPLY.

A. CHOICE TO PROLONG OR NOT TO PROLONG LIFE

_____ YES, I do want to have my life prolonged as long as possible within the limits of generally accepted health care standards that apply to my condition.

OR

_____ NO, I do not want my life prolonged.

B. ARTIFICIAL NUTRITION AND HYDRATION (FOOD AND FLUIDS) BY TUBE INTO STOMACH OR VEIN

_____ YES, I do want artificial nutrition and hydration.

OR

_____ NO, I do not want artificial nutrition and hydration.

C. RELIEF FROM PAIN

_____ YES, I do want treatment to relieve my pain or discomfort.

OR

_____ NO, I do not want treatment to relieve my pain or discomfort.

D. ETHICAL, RELIGIOUS, OR SPIRITUAL INSTRUCTIONS (OPTIONAL)

Is there a church, temple, spiritual group or a special person from whom you wish to receive spiritual care?

Name: Phone

Street Address City State Zip

E. DO YOU WANT HOSPICE CARE, IF APPROPRIATE? ____ YES ____ NO

(Hospice provides physical, psychosocial, emotional, and spiritual support and counseling for the patient and his/her family. Hospice is available in home, hospital, hospice-unit, and nursing home settings.)

F. PRIMARY CARE PHYSICIAN

Name: Phone

G. OTHER WISHES:

If you do not agree with any of the choices above or wish to add other instructions, including body and organ donation, you may add pages. If you are or could become pregnant, consult your doctor, and consider adding special instructions suspending or adding provisions. Remember to sign, date, witness or notarize additional pages.

File a copy of your Advance Health Care Directive with: ☐ *Doctor* ☐ *Family* ☐ *Agent*

PART 2: HEALTH CARE POWER OF ATTORNEY AGENT'S AUTHORITY AND OBLIGATION

My agent shall make health care decisions for me in accordance with my best interests and wishes so far as they are known. In determining my best interest, my agent shall consider my personal values. If a guardian of my person needs to be appointed for me by a court, I nominate my agent. I designate the following individual as my agent. He/she may make all health care decisions for me if I am unable or unwilling to make them for myself unless I direct otherwise:

Name of Agent (Spouse, adult child, friend or other trusted person) Relationship

Street Address City State Zip

Home Phone Work Phone E-mail

If my agent is not available, I designate the following person as my alternative agent:

Name of Alternate Agent (Spouse, adult child, friend or other trusted person) Relationship

Street Address City State Zip

Home Phone Work Phone E-mail

____ My agent may make all health care decisions for me. **OR**
____ My agent may make all health care decisions for me except:_____
____ My agent's authority becomes effective when my primary physician determines that I am unable to make health care decisions. **OR**
____ My agent's authority to make health care decisions for me takes effect immediately.

YOUR NAME:_____
Print Your Full Name Your Signature Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.
Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1:
WITNESSES

Witness #1 Print Name Witness Signature Date

Street Address City State Zip

Witness #2 Print Name Witness Signature Date

Street Address City State Zip

OPTION 2: NOTARY PUBLIC
State of Hawai'i, _____ (County). On this _____ day of _____, in the year _____, before me, _____, (insert name of notary public) appeared _____ _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he or she executed it.

_____

My Commission Expires:_____

A copy has the same effect as the original.

Developed by the Executive Office on Aging, State of Hawai'i – Revised September 2003.

CHECKLIST:

_____ **Talk with your spouse, partner, adult children, family, friends, spiritual advisors, and doctors** about what would be important to you.

_____ **Ask someone you trust and can count on to be your health care agent**. Discuss your wishes with this person. Select an alternate health care agent in case your agent is unable to serve.

_____ **Complete the enclosed optional Advance Directive** or make a document of your own. You can add more pages if needed.

_____ **Have two qualified witnesses or a notary public** witness your signature.

_____ **Inform family, friends, and doctors that you have an Advance Directive** and that you expect them to honor your wishes. Keep them informed about your current wishes.

_____ **Give copies of the Advance Directive** to your health care agent, health care providers, family, close friends, spiritual advisors, and any other individuals who might be involved in your care.

_____ **Place copies in your medical files**.

_____ **Keep a copy in any easy to find place in your home**. (Not in a safe deposit box!!) You could leave a note on the refrigerator to tell people where your important documents are so they can be found when they are needed.

_____ You may designate **"Advance Directive" on your driver's license or state identification card** to indicate that you have completed an Advance Directive and wish it to be honored. Hawai'i drivers' license stations do not file Advanced Directives.

_____ **Review your Advance Directive regularly**. In case you make changes, inform people, create a new document, and replace the old one.

_____ **Learn about POLST:** Do you need POLST (Physician's Orders for Life Sustaining Treatment) in addition to an Advance Directive? Talk with your doctor about POLST and visit *www.kokuamau.org/polst* for more information for you and for your physician as well as the POLST form.

This brochure provides general information and does not constitute legal advice and may not apply to your individual situation.

Developed by Kōkua Mau and the Executive Office on Aging, State of Hawai'i. Checklist originally developed by UH Elder Law Program. *Revised*: *August 2012*

YOUR ADVANCE DIRECTIVE FOR FUTURE HEALTH CARE

It is your gift to loved ones, family members and friends
so that they won't have to guess what you want
if you no longer can speak for yourself

Kōkua Mau
"Continuous Care"
Hawai'i Hospice and Palliative Care Organization

Executive Office on Aging
Department of Health

WHY DO I NEED AN ADVANCE HEALTH CARE DIRECTIVE?

Medical technology has given us many new options for sustaining life. This makes it important for you to discuss what kind of care you want before serious illness or accident occurs.

Now is the time to talk about these important issues while you can still make your own decisions and have time to talk about them with others.

If you don't have an Advance Health Care Directive, (commonly known as 'Advance Directive'), and even one person interested in your care disagrees, your doctor may not honor your wishes for end-of-life care.

The Advance Directive takes the place of the former living will document and gives you more options. Review your existing forms to decide if an Advance Directive will better reflect your wishes.

WHAT DO I PUT IN MY ADVANCE DIRECTIVE?

THE KIND OF HEALTH TREATMENT YOU WANT OR DON'T WANT.

You can say whether or not you want to be kept alive by machines that breathe for you or be fed by a tube even if there is no hope you will get better.

YOUR WISHES FOR COMFORT CARE.

You can indicate whether you want medicine for pain or where you want to spend your last days. You can also give spiritual, ethical, and religious instructions.

THE PERSON OR "AGENT" YOU WANT TO MAKE DECISIONS FOR YOU WHEN YOU CANNOT.

You can identify someone you trust to act as your agent. This person does not have to be an attorney. Unless you limit this person's authority, this person has the right to accept or refuse any kind of medical care and testing, discharge or select doctors, and see all medical records.

HOW CAN I ENSURE MY ADVANCE DIRECTIVE IS HONORED?

Share copies and talk with loved ones, family, and others who will be involved in your care. Ask all your doctors to insert your Advance Directive into your medical records.

INSTRUCTIONS FOR ADVANCE DIRECTIVE

(in accordance with the Uniform Health Care Decisions Act, 1999)

Complete Part 1 and 2 on the enclosed form. You may add pages and make any changes you wish. You do not need an attorney to complete this form. If you need more help, consult the phone numbers included in this brochure. Complete the check list on the back page.

PART 1 – INDIVIDUAL INSTRUCTION
Give instructions to your doctor and others about any aspect of your health care. You will be given choices. Check only one box in each category and cross out all which do not apply.

PART 2 – HEALTH CARE POWER OF ATTORNEY, YOUR AGENT
Select one or more persons to be your agent and make health care decisions if you are unable. The person you appoint can be a spouse, adult child, friend, or any other trusted person. Your agent cannot be an owner or employee of a health care facility where you are receiving care unless they are related to you.

Ask two witnesses to sign and date the form
Both must be people you know. They cannot be health care providers, employees of a health care facility, or the person you choose as an agent. One person cannot be related to you or have inheritance rights.

Notary Public
If you do not have 2 witnesses, your Advance Directive must be notarized.

You have the **right to revoke or change your Advance Directive at any time** orally or in writing. Be sure to tell your agent and doctor.

WHO CAN HELP ME COMPLETE MY ADVANCE DIRECTIVE?

Talk with your health care provider
Legal Aid Senior Hotline: 1-888-536-001
Kaua'i: Seniors Law Program **808-246-8868**
Maui, Moloka'i, Lana'i: Legal Aid Society **808-242-0724**
O'ahu: UH Elder Law Program, **808-956-6544**, www.hawaii.edu/uhelp
Hawai'i: Legal Aid Society, Hilo: **808-934-0678** - Kona: **329-8331**

For further information contact:
Kōkua Mau, Hawai'i Hospice and Palliative Care Organization
- For Advance Directives (also as a writable pdf) please visit: www.kokuamau.org/resources/advance-directives.
- Kōkua Mau Speaker's Bureau can provide speakers about Advance Care Planning (Advance Directives and POLST).

www.kokuamau.org • info@kokuamau.org • (808) 585-9977
Kōkua Mau • P.O. Box 62223 • Honolulu HI 96839