**ADVANCE HEALTH CARE DIRECTIVE FORM**

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### 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?

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**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**

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**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 with:

- Doctor copy
- Family Copy
- Agent Copy
- www.myhealthdirective.com
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 _____________

Address ____________________________ City ____________________________ State _______ Zip Code

Witness #2 Print Name ____________________________ Witness Signature ____________________________ Date _____________

Address ____________________________ City ____________________________ State _______ Zip Code

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.

It is a gift to family members and friends so that they won’t have to guess what you want if you no longer can speak for yourself.

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

CHECKLIST:

____ Talk with your spouse, 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 Health Care 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, spiritual advisors, and any other individuals who might be involved in your care that you have an Advance Health Care Directive and that you expect them to honor your wishes.

____ 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.

____ Place copies in your medical files.


____ Keep these instructions about your current wishes.

____ Create a new document and replace the old one.

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

____ Select an alternate health care agent in case your agent is unable to serve.

____ 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.

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Developed by the Executive Office on Aging, State of Hawaii.

Checklist originally developed by UH Elder Law Program.

Revised April 2002.
INSTRUCTIONS FOR ADVANCE HEALTHCARE 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 box on the back page.

WHO CAN HELP ME COMPLETE MY ADVANCE DIRECTIVE?

Kauai:
Seniors Law Program
808-246-0573

Maui, Molokai, Lanai:
Legal Aid Society
808-242-0724

Oahu:
UH Elder Law Program
956-6544
www.hawaii.edu/uhelp

Big Island:
Legal Aid Society (Hilo)
808-934-0678
(Kona)
808-329-8331

For further information contact:
Kokua Mau
(Continuous Care) website at
www.kokuamau.org.

Kokua Mau Speaker’s Bureau: (800) 474-2113.

WHY DO I NEED AN ADVANCE DIRECTIVE?

Medical technology has given us many new options for sustaining life. It 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.

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 fed 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 which hospices and other medical care providers you want to give instructions to your doctor and other people who see your records.

THE PERSON OR "AGENT" YOU WANT TO MAKE DECISIONS FOR YOU WHEN YOU CANNOT.
This person does not have to be an attorney. Unless you limit your agent's authority, your agent has the right to accept or refuse any kind of medical care and testing, discharge or select doctors, and make medical decisions for you. Your agent cannot be an owner or employee of a health care facility where you are receiving care unless they are related to you.

IF YOUR AGE IS 18 OR OLDER, ANYONE ELSE CAN HELP YOU MAKE DECISIONS.
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.

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You can say whether or not you want to be kept alive by machines that breathe for you or feed you 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.
This person does not have to be an attorney. Unless you limit your agent's authority, your agent has the right to accept or refuse any kind of medical care and testing, discharge or select doctors, and make medical decisions for you. Your agent cannot be an owner or employee of a health care facility where you are receiving care unless they are related to you.

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