

# 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 with:

- Doctor copy     Family Copy     Agent Copy     [www.myhealthdirective.com](http://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.

|                   |                             |                       |             |
|-------------------|-----------------------------|-----------------------|-------------|
| <b>YOUR NAME:</b> | <b>Print Your Full Name</b> | <b>Your Signature</b> | <b>Date</b> |
|-------------------|-----------------------------|-----------------------|-------------|

**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.

