

# Advance Health Care Directives

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# ADVANCE HEALTH CARE DIRECTIVE

## GENERAL INFORMATION

### 1. What is an Advance Directive?

An Advance Directive provides a way for people to direct their own healthcare even when they are in a coma, have dementia or are mentally incapacitated or unable to communicate. A person can use an Advance Directive to spell out her wishes regarding physical and mental healthcare and to select someone to make health care decisions when she is unable to do so.

In California, an Advance Directive is made of up two parts, (1) Appointment of an Agent for Healthcare and (2) Individual Health Care Instructions. A person may choose to complete either one or both of these parts. Either part is legally binding by itself.

### 2. What is a Healthcare Agent?

A person may use her Advance Directive to appoint a Healthcare Agent. A Healthcare Agent is responsible for making healthcare decisions should the person lose the ability to make these decisions for herself. A Healthcare Agent is responsible for carrying out the person's wishes as she has expressed them in her Advance Directive or in discussions with the Agent.

It is not necessary to name a Healthcare Agent in order to complete an Advance Directive. If the person has not chosen a Healthcare Agent, the healthcare provider is still required to follow the person's wishes, as expressed in the Individual Healthcare Instructions.

If both parts of the Advance Directive are filled out, the Healthcare Agent must follow the specific wishes spelled out in the second part of the document which is called the Individual Healthcare Instructions.

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A single gender (female) is used to simplify the writing style, but all information applies to both men and women.

### **3. What are Individual Healthcare Instructions?**

Individual Healthcare Instructions are the way in which a person can tell her doctor, family or Agent what her decisions are regarding physical or mental health treatment. Individual Healthcare Instructions are verbal or written directions about health care. A person can use Individual Healthcare Instructions to let her healthcare provider know what she wants done and under what circumstances. This may include agreeing to certain treatments or refusing specific treatments or services.

### **4. What can an Advance Directive do for a person with a psychiatric disability?**

A person with a psychiatric disability can benefit from having an Advance Directive in a number of ways:

An Advance Directive can empower the person to make her treatment choices known in the event she needs mental health treatment and is found to be incapable of making healthcare decisions.

An Advance Directive can improve communication between the person and her doctor. Completing an Advance Directive is a good way to open up discussion with healthcare providers about treatment plans and the full spectrum of choices in treatment.

An Advance Directive can help the person prevent clashes with family members and/or healthcare providers over treatment during a crisis by allowing those discussions to take place when a person is filling out her Advance Directive.

Completing an Advance Directive creates an opportunity for the person to discuss her wishes in detail with family and/or friends. This may help family and/or friends more effectively advocate for the person when she is unable to advocate for herself and to advocate in ways that reflect the person's wishes.

An Advance Directive may prevent forced treatment.

An Advance Directive may reduce the need for long hospital stays.

## **5. Who can fill out an Advance Directive?**

Any person 18 years or older who has the “capacity” to make health care decisions may fill out an Advance Directive. “Capacity” to make healthcare decisions means the person understands the nature and consequences of the proposed healthcare, including the possible risks and benefits and is able to make and communicate decisions about that healthcare. Legally, a person is assumed to be competent unless proven otherwise.

## **6. How does an Advance Directive become official?**

An Advance Directive must contain all of the following to be official:

- A statement of the person’s intent to create an Advance Directive.

- The signature of the person writing the Advance Directive

- The signatures of either two witnesses or a notary public

- The date the Advance Directive was signed.

## **7. When does an Advance Directive go into effect?**

An Advance Directive only goes into effect when the person’s primary physician decides that the person does not have the “capacity” to make her own healthcare decisions. This means the physician believes that the person is not able to understand the nature and consequences of proposed healthcare or is not able to make or communicate her healthcare decisions. The fact that a person has been admitted to a mental health facility does not, in itself, mean that the person lacks capacity to make her own healthcare decisions.

The Advance Directive is no longer in effect as soon as the person regains the capacity to make her own healthcare decisions.

## **8. Who can help with filling out an Advance Directive?**

Writing an Advance Directive can sometimes seem confusing or complicated. If a person needs help writing her Advance Directive, she should ask someone who respects her right to make these decisions for herself and will help without pressuring her to make one decision or another.

It also a good to ask someone who is knowledgeable or experienced in writing Advance Directive to help. The Office of Medi-Cal Ombudsman Services for Mental Health can help people in finding someone nearby to answer questions and assist in writing Advance Directives. The telephone number for Ombudsman Services for Mental Health is (800) 896-4042.

## **9. Is a Healthcare Agent necessary?**

No, a person does not have to name a Healthcare Agent in order to write a valid Advance Directive. Someone who does not have a trusted family member or friend may choose not to name a Healthcare Agent. If the person does not have a Healthcare Agent, her healthcare provider must still follow her wishes as expressed in her Individual Healthcare instructions.

However, there are good reasons to name a Healthcare Agent. A Healthcare Agent can advocate for the person when she is unable to advocate for herself and can ensure that the person's choices are respected. A Healthcare Agent can also contact others for assistance in enforcing the Advance Directive if the person's choices are being ignored. This is why it is so important for the person to choose only someone she knows and trusts to be her Healthcare Agent.

Whether or not to name an Agent and who to name as Agent are two of the most important decisions a person will have to make when writing an Advance Directive.

## **10. What happens when a person wants to change an Individual Healthcare Instruction?**

The requirements for changing any Healthcare Instruction are the same as those for completing an Advance Directive.

To change an Individual Healthcare Instruction, the person must

- be at least 18 years old,
- be acting freely and without pressure from anyone, and
- have the "capacity" to make healthcare decisions.

A person can change an Individual Healthcare Instruction by writing a new Advance Directive with the changes in it that she wants to make. If the person writes a new Advance Directive she must take all the same steps she did in writing the first Advance Directive, including having it witnessed.

A person can also revoke their Advance Directive orally, by telling their healthcare provider that they no longer want either the entire document or any parts of it enforced.

### **11. Who should have a copy of the Advance Directive?**

The person should keep a copy of the Advance Directive for herself in a place that is safe, but easily accessible.

The person should give a copy of the Advance Directive to her Agent if she has one. The Agent's job is to make sure that the person's decisions are known and followed. To do this, the Agent must have a copy of the Advance Directive that appoints her as the person's Agent.

Each of the person's healthcare providers should have a copy of the Advance Directive and are legally required to place the Advance Directive in the person's medical records. This is important because the healthcare provider cannot follow the person's Individual Healthcare Instructions unless they know what those instructions are. If the person does not have an Agent or the Agent is unavailable, the healthcare provider will still know what the wishes are if the document includes Individual Healthcare Instructions.

The person should keep track of who has a copy of her Advance Directive. If the patient decides to change or revoke (cancel) her designation of an Agent or any individual healthcare instruction, she should let everyone who has a copy of the Advance Directive know about the change/revocation to avoid confusion.

### **12. Does a healthcare provider have to follow an Advance Directive?**

Yes. Healthcare providers must follow both the person's Individual Healthcare Instructions and the decisions made on the person's behalf by her Agent.

### **13. Who can help if an Advance Directive is ignored/not followed?**

If a healthcare provider refuses to follow the person's Individual Healthcare Instructions or refuses to comply with the decisions of the person's Agent, contact the county patients' rights advocate and/or Protection and Advocacy Incorporated (PAI). PAI and the county patients' rights advocate can work with the person or her Agent to make sure that the Advance Directive is followed.

The telephone number for Protection and Advocacy, Inc is **(800) 776-5746** and the telephone numbers for county patients' rights advocate are posted on the walls in all inpatient mental health facilities.



# ADVANCE HEALTH CARE DIRECTIVE

## EXPLANATION OF TERMS FOR ADVANCE DIRECTIVES

The first part of your Advance Health Care Directive is written to inform the reader of the Codes in both federal and state law that apply to the Advance Directives you have written.

The listing of specific codes at the end of paragraphs is included so that people can check them out, if they wish. Mostly, attorneys and health care providers need to know these; consumers may go to the regulations listed if they want to become better informed of their rights.

Some important legal terms in this section are:

1. Capacity – in this document, “capacity” refers to your ability to understand, make and communicate your healthcare decisions; when you are determined to “lack capacity” to do this is when the Advance Directive goes into effect.
2. Duration – in California there is no automatic time limit on an Advance Directive. Unless you state a specific date when you want your document to expire, your Advance Directive stays in effect until you decide to revoke it.
3. Revocability – in California you have the right under the law to say all or any part of your Advance Directive is no longer binding.
4. Liability – in California health care providers can be sued for “damages” (including fines and attorney’s fees) if they are found to have failed to follow an Advance Health Care Directive.
5. Immunity – In California health care providers who are following an Advance Directive in good faith are protected from being prosecuted for a crime and from being sued for complying with the Advance Directive.

6. Discrimination – in California no one can make you have an Advance Health Care Directive, or take away your right to have one, as a condition for giving you health care, or admitting you to a place of treatment, or providing you with insurance.

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

7. Health Care Agent – This is the person you choose to speak for you and assert your health care decisions. Although you do not *have* to choose an agent under California law, you may want to choose someone who is willing to represent your wishes with regard to your health treatment.
8. Conservator – this is someone whom the court may appoint to oversee your affairs and make treatment decisions if you are determined by the court to be unable to provide for your own basic needs due to a mental disorder. You may want to identify someone whom you prefer to be your conservator, in case the court decides to do this.

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

9. Incapacity – this is another way of saying that you “lack capacity.” It means you are not able to make or communicate your own health care decisions at a particular time.
10. Treatment Facility – this would be any licensed place that is permitted by law to provide psychiatric care on a 24-hour basis. It is often a hospital.
11. Primary Physician – for the purposes of this section, this is the medical doctor who has been identified by you as the one who has first responsibility for providing your mental health care.

12. Emergency Situations – these are the kinds of crises that mental health treatment facilities often see as justifying the use of such methods as *seclusion* and *restraint* in order to control you.
  - a. Seclusion – a method of control that removes you and isolates you by making you stay in a separate area.
  - b. Restraint – a method of control that physically limits your ability to move.
13. Side Effects – the usually unpleasant or destructive things that may happen to your body when you take certain medications.
  - a. *Tardive Dyskinesia* – movements of the face, hands, etc. that are not able to be stopped at will that are the side effects of taking certain medications.
  - b. *Motor Restlessness* – being unable to stop yourself from moving as a side effect of taking certain medications.
  - c. *Muscle/Skeletal Rigidity* – extreme stiffness that is a side effect of taking certain medications.
  - d. *Neuroleptic Malignant Syndrome* – the name given to a group of sometimes life-threatening side effects to certain medications.
14. Electroconvulsive Therapy – sometimes called ECT or “shock treatments,” this involves the use of electricity to provoke controlled brain seizures, and is sometimes used in the treatment of depression.
15. Drug Trials – this is the use of people as subjects of research for the testing of new medications.

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

16. Life Sustaining Treatment – this is the term doctors and hospitals use to describe the technology and machinery that has been invented to prolong life when otherwise a person would die.

17. Persistent Vegetative State – this is the term used to describe a human being whose ability to function has been severely reduced, who is being kept alive on machines.
18. Anatomical Gift – this is the donation of all or part of your body for medical or scientific purposes after you have died.
19. Autopsy – this is the medical examination of your body after death to determine the cause of death.

# **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 Protection and Advocacy, Inc. (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: \_\_\_\_\_

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## 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: \_\_\_\_\_  
\_\_\_\_\_



**14. Statement of Desires, Special Provisions and Limitations**

\_\_\_\_ A. I specifically express the following desires concerning these health care decisions:

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\_\_\_\_ B. And I specifically limit this Advance Directive as follows:

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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.)*

## 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.

\_\_\_\_\_  
(Signature)

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

\_\_\_\_\_  
(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.**