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Advance Healthcare Directive

Introduction to Advance Care Planning

At UCLA Health, we want to be a partner in your healthcare decisions. We strive to provide the best medical care to achieve each patient's health objectives. It is important for you, as a patient, to be fully informed about your health, and to have the opportunity to express your personal healthcare goals. When the members of your healthcare team know what is important to you, they can best apply their medical expertise to help you reach those goals.

Advance care planning enables you to work with your healthcare team so they understand your perspectives and can integrate them into future treatment recommendations. Your healthcare team wants you to think about your values and preferences to guide the medical care you receive. This is an opportunity for you to think about what future health states you desire (for example, being able to carry out certain activities) and what situations you want to avoid (for example, being kept alive on machines while in a coma). You can discuss your wishes with your healthcare team and record them in this document. You can also indicate your healthcare agent, someone you would want to make decisions for you if you are unable to do so. This advance directive form is to record those wishes.

Use this advance directive to direct your future medical care as follows:

Pages 2–4: Identify and write down your values and healthcare goals

Pages 5–6: Appoint a person who could speak for you if you can't speak for yourself

Page 7: Consider organ donation

Pages 8–10: Sign the form with witnesses or a notary present to make it legal

After you have completed your advance directive, discuss it with your healthcare team. They will place the document in CareConnect, UCLA's electronic health record.

Your values and goals

Your healthcare team will use medical treatments to try to achieve your goals. When people are seriously ill, many people think about treatment goals in terms of how they are willing to live.

I would not want medical treatments to try to keep me alive if I could no longer:

(Check each statement you agree with)

- ☐ live without being permanently hooked up to a breathing machine
- ☐ recognize family and friends
- ☐ talk to family and friends
- ☐ feed, bathe or take care of myself
- ☐ live without severe pain or discomfort
- ☐ think well enough to make everyday decisions

Other: _____

_____

_____

_____

- ☐ I'm not sure
- ☐ None of the above apply. My life is always worth living, no matter how sick I am.

Sometimes when a person is very sick, life-support treatments are used while the healthcare team tries to help the person get better. These treatments may include CPR, a breathing tube or dialysis. Considering the statements that you chose above, would you want to receive life-support treatments:

(Choose one)

- ☐ **Never**, under any circumstances
- ☐ **Only** if the chances are **high** of surviving to live in a way acceptable to me
- ☐ If the chances are at least **moderate** of surviving to live in a way acceptable to me
- ☐ **Even** if the chances are **low** of surviving to live in a way acceptable to me
- ☐ I would want my healthcare agent to decide this for me, if needed

For more information about life-support treatments, ask your physician.

Your values and goals (Continued)

If you have wishes or thoughts about receiving or not receiving life-support treatments like CPR, a breathing tube, dialysis, feeding tube or other treatments, such as blood transfusions, write them here. These wishes will be used as healthcare instructions to your healthcare agent.

Please write any other beliefs or values that you would want your healthcare agent to know if you become unable to speak for yourself.

Is there anything you want your healthcare team to know about your religion or spirituality?

Is there a religious/spiritual leader from the community you want to be involved?

(Provide contact information)

If I am so ill that I will not recover, I would prefer to die, if possible:

(Choose one or more of the following options)

- ☐ At home under the care of hospice
- ☐ In the hospital
- ☐ In a skilled nursing facility
- ☐ Not sure, my healthcare agent can decide this
- ☐ Where I die is not important to me

Choosing your healthcare agent

A **healthcare agent** is the person you choose to make medical decisions for you when you can no longer make them for yourself. This may be the person who cares the most about you, the person you are closest to, or the person you feel will fulfill your wishes. You will appoint your healthcare agent in this advance directive.

You should talk with the person that you choose to be your healthcare agent for two reasons:

- to make sure your healthcare agent knows that he or she is your healthcare agent
- to make sure your healthcare agent knows about your healthcare goals and values so he or she can make the decisions you would want

Most people choose a spouse, child or sibling to be their healthcare agent, but your healthcare agent can be another relative or a close friend.

Role of a healthcare agent

Your healthcare agent will be able to make nearly any medical decision that you could make for yourself.

Your healthcare agent will be able to:

- speak with your healthcare team about your condition and treatment options
- choose healthcare providers and the location of medical treatment
- review your medical record and authorize its release when needed
- accept or refuse medical treatments, including artificial nutrition and hydration and CPR
- decide about tissue and organ donation and autopsy
- decide about care for your body after death

Your healthcare agent should be:

- legally able to serve as your agent (at least 18 years old and not your healthcare provider or an employee of your provider, unless this person is your spouse or a close relative)
- available when needed and willing to make decisions on your behalf
- comfortable asking questions of your healthcare team and able to make the healthcare decisions you would want

Naming your healthcare agent

If you are not able to make decisions for yourself, your values and preferences will guide your treatment. If other decisions are needed, your healthcare agent will make healthcare decisions for you.

My healthcare agent will make decisions for me **only** after I cannot make my own decisions.

If I am unable to make my own healthcare decisions, I want the following person to do so:

First name _____ Last name _____

Relationship _____

Address _____

City _____ State _____ Zip code _____

Home phone _____ E-mail _____

Work phone _____

Mobile phone _____

If the person listed above cannot make decisions for me, then I want the following person to make my medical decisions:

First name _____ Last name _____

Relationship _____

Address _____

City _____ State _____ Zip code _____

Home phone _____ E-mail _____

Work phone _____

Mobile phone _____

Have you discussed your healthcare preferences with your healthcare agent?

☐ Yes

☐ No → It is important for you to talk with your healthcare agent.

Organ and tissue donation

Donating your organs and tissues when you die can save the lives of others. Indicate below whether you want to donate your organs.

☐ I **want** my organs donated when I die. Which organs do you want to donate?

- ☐ any organ
- ☐ only (specify): _____

☐ I **do not** want to donate my organs.

☐ I would want my healthcare agent to decide.

To learn more about which organs or tissues can be donated, or to register as an organ donor with the state of California, visit donatelifecalifornia.org.

Body donation

Donating your body to UCLA for medical education and research will help train the next generation of doctors and promote anatomical research. Indicate below whether you would want your body donated.

☐ **I want my body donated when I die.**→ If you would like to donate your body, there are preparatory steps to take. To learn more and receive a donor packet, visit **donatedbodyprogram.ucla.edu** or call (310) 794-0372.

Is there anything that you would like your healthcare providers to know about how you want your body to be cared for after you die?

Signing the form

This form cannot be used by your healthcare providers to honor your wishes until you sign the form and:

get two witnesses to sign the form

or

have it notarized by a state licensed notary public

Sign your name and write the date in the presence of two witnesses or a notary.

Signature _____ Date _____

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____ Phone _____

Two witnesses sign the form

If you have two witnesses, have them sign below. If not, take this form to a notary public.

Your witnesses must

- be over 18 years of age
- know you
- see you sign this form

Your witnesses cannot

- be your healthcare agent
- be your healthcare provider
- work for your healthcare provider
- work at the nursing home where you live (if you live in a nursing home)

Also, one of the witnesses cannot:

- be related to you in any way
- benefit financially (get any money or property) after you die

Have your witnesses sign their names and write the date.

By signing, I confirm that _____ **signed this form while I watched.**

He/she was thinking clearly and was not forced to sign this form.

I also confirm that the following are true:

- I know him/her or this person could prove who he/she is
- I am 18 years or older
- I am not his/her healthcare agent
- I am not his/her healthcare provider and don't work for his/her healthcare provider
- I do not work where he/she lives (if living in a nursing home)

Witness #1

Signature _____ Date _____

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____ Phone _____

Witness #2

Signature _____ Date _____

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____ Phone _____

Witness 1 or 2 also must sign the statement below:

I also confirm that the following are true:

- I am not related to the person who signed this form by blood, marriage or adoption
- I will not benefit financially (receive money or property) after he/she dies

Signature: _____

This advance directive is now complete. Share this form with your healthcare team, healthcare agent and family. This document should be placed in CareConnect, UCLA's electronic health record. You have the right to revoke or change this advance directive at any time.

Notary Public

If two witnesses have not signed this form, take this form to a notary public.

Please bring a government-issued photo I.D. (driver's license, passport, etc.)

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

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 that document.

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. [Civil Code Section 1189]

Signature: _____
**(Notary Public)*

(Please place Notary seal above)

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