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.