Advance Healthcare Directive

An easy-to-use form to make your goals, values and preferences known

Cedars-Sinai®

Why should you have an Advance Healthcare Directive?

It is important to plan ahead and clearly state your healthcare goals, values and preferences. An Advance Healthcare Directive is the best place to do this. Your completed directive will give you and those close to you greater peace of mind. The process of filling out your directive may also help you talk with loved ones about what matters most to you.

There also is a number of resources available at Cedars-Sinai to help you complete your directive, including social workers, spiritual care experts and a free Advance Care Planning class. For information on these and other resources, please see the back cover of this document.

What should you do after you have completed your Advance Healthcare Directive?

1. Have your directive notarized or signed by two eligible witnesses.
   - Option 1: Sign the document in the presence of a notary public.
   - Option 2: Have two eligible witnesses sign the document.
2. Share copies with:
   - Your healthcare agent(s)
   - Your loved ones
   - Your main physician
   - Your lawyer
3. Make sure it is uploaded into your electronic medical record, using one of the following options:

Upload to My CS-Link™	Fax to Cedars-Sinai	Mail to Cedars-Sinai	Email an electronic copy to Cedars-Sinai
Website: **mycslink.org** Use the Advance Healthcare Directive page listed under Resources. *Please include your name and date of birth on the first page.*	**Fax Number:** **310-248-8078** *Please include your name and date of birth on the first page.*	**Mailing Address:** **Health Information Department** **8700 Beverly Blvd.** **South Tower, Room 2901** **Los Angeles, CA 90048** *Please include your name and date of birth on the first page.*	**Email Address:** **groupMNSHID@cshs.org** *Please include your name and date of birth on the first page.*

4. Keep the original copy in a safe (but accessible) place.

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My Name: ____________________

My Date of Birth: ____________________

PART 1:
My Healthcare Agent

SECTION A | CHOOSING MY HEALTHCARE AGENT

- **For help with filling out this section, please refer to Part 1 Section A of the Step-by-Step Guide (Pages 3-4).**

I choose the following person to speak on my behalf if at any time I am not able to (or choose not to) express my own goals, values and preferences:

Healthcare Agent's Name: ____________________

Relationship to You: ____________________

Phone Number(s): ____________________

Email Address (if known): ____________________

The following person(s) can serve as alternate agents (this is optional):

First Alternate

Alternate Agent's Name: ____________________

Relationship to You: ____________________

Phone Number(s): ____________________

Email Address (if known): ____________________

Second Alternate

Alternate Agent's Name: ____________________

Relationship to You: ____________________

Phone Number(s): ____________________

Email Address (if known): ____________________

SECTION B — WHEN WOULD I LIKE MY HEALTHCARE AGENT TO BEGIN REPRESENTING ME?

- **For help with filling out this section, please refer to Part 1 Section B of the Step-by-Step Guide (Page 5).**

I would like my healthcare agent to begin participating in decision-making about my healthcare at the following time:

Please complete the sentence above by initialing either option 1 or option 2:

Option 1

When my physician determines that I am unable to express my own goals, values and preferences.

____

(Initial Here)

OR

Option 2

From this time forward, even if I am still able to speak for myself.

____

(Initial Here)

PART 2:
My Healthcare Goals, Values and Preferences

SECTION A | QUALITY OF LIFE

- **For help with filling out this section, please refer to Part 2 Section A of the Step-by-Step Guide (Pages 6-9).**

My life would be worth living, and therefore I would want my life to be prolonged as long as possible, under the following circumstances:

Please complete the sentence above by selecting option 1, 2 or 3:

Option 1

☐ All circumstances—even if it means only the basic functioning of my organs (heart, lungs, kidneys, etc.) with or without machines.

OR

Option 2

☐ All circumstances, unless I would NEVER recover the ability to (please fill in the space below):

Physical and Bodily Considerations (e.g., live without being permanently connected to mechanical life support, get out of bed, go outside):

____

____

____

Cognitive Considerations (e.g., be awake, be conscious, be able to think clearly):

____

____

____

Interactive, Social and Community Considerations (e.g., communicate in some way with other people, live outside of a healthcare facility):

____

____

____

OR

Option 3

☐ I am not sure.

If you would like to share additional details, please use any of the lined spaces provided on page 6 or at the end of this document.

SECTION B | SCOPE OF TREATMENT

- **For help with filling out this section, please refer to Part 2 Section B of the Step-by-Step Guide (Pages 10-11).**

If my physician believes that I have a reasonable chance of recovering to the quality of life I stated on page 4, I would be willing to undergo the following:

Please complete the sentence above by selecting option 1, 2 or 3:

Option 1

☐ All procedures, treatments and interventions offered by my healthcare team.

OR

Option 2

☐ All procedures, treatments and interventions offered by my healthcare team, EXCEPT:

____

____

____

____

____

____

____

____

____

____

____

____

____

OR

Option 3

☐ I am not sure.

If you would like to share additional details, please use any of the lined spaces provided on page 6 or at the end of this document.

SECTION C | FURTHER EXPLANATION (OPTIONAL)

If you would like to share more thoughts and information, you may do so here. This is a good place to mention any cultural or religious views that influence your healthcare goals, values and preferences.

If you would like to share additional details, please use any of the lined spaces provided at the end of this document.

PART 3 (OPTIONAL):
Additional Preferences

- **For help with filling out this section, please refer to Part 3 of the Step-by-Step Guide (Page 12).**

Organ Donation

☐ I wish to donate any and all organs and tissues.

OR

☐ I do not wish to donate any of my organs or tissues.

OR

☐ I wish to donate only the following organs or tissues (please specify):

____

____

____

____

My Wishes for After I Die

I have the following wishes regarding funeral, burial and/or cremation arrangements:

____

____

____

____

____

____

____

If you would like to share additional details, please use any of the lined spaces provided at the end of this document.

PART 4:
How Strictly Do I Want My Advance Healthcare Directive Followed?

- **For help with filling out this section, please refer to Part 4 of the Step-by-Step Guide (Page 13).**

I want my goals, values and preferences as written in this directive to:

Please complete the sentence above by initialing either option 1 or option 2:

Option 1
Serve as a general guide, based on what I know now.

____

(Initial Here)

OR

Option 2
Be followed strictly, under all circumstances.

____

(Initial Here)

If you would like to share more thoughts and information, please use the space below:

____

____

____

____

____

____

If you would like to share additional details, please use any of the lined spaces provided at the end of this document.

PART 5 (OPTIONAL):
Identifying My Physician

- **For help with filling out this section, please refer to Part 5 of the Step-by-Step Guide (Page 14).**

You may have physicians involved in your care who understand your goals, values and preferences. If you would like them to be involved in discussions regarding your condition and treatment options, please list their names and contact information below.

Name of Physician: ____________________

Phone Number(s) (if known): ____________________

Email Address (if known): ____________________

Name of Physician: ____________________

Phone Number(s) (if known): ____________________

Email Address (if known): ____________________

Name of Physician: ____________________

Phone Number(s) (if known): ____________________

Email Address (if known): ____________________

Please remember also to discuss your values and choices with the physician(s) named above and provide him/her/them a copy of your directive.

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PART 6:
Signing My Advance Healthcare Directive

■ **For help with filling out this section, please refer to Part 6 of the Step-by-Step Guide (Page 15).**

In order to make this document legal and valid, you must sign below in the presence of EITHER a **notary public** (Page 13) OR **two witnesses** (Page 14):

Name (Print):

____

Signature:

____

Date of Signature:

____

This page left intentionally blank

Signing My Advance Healthcare Directive

With a Notary

Note: If you complete the section below, you do not need to complete Page 14.

NOTARIZATION

(California All-Purpose Acknowledgment, Civil Code 1189)

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 ______________ before me, ____
Date *Here Insert 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.

Signature ____
Signature of Notary Public

Place Notary Seal Above

Signing My Advance Healthcare Directive

With Witnesses

Note: If you complete the section below, you do not need to complete Page 13.

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California 1) that the individual who signed or acknowledged this Advance Healthcare 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 Healthcare 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 Healthcare Directive; and 5) that I am not the individual's healthcare provider, an employee of an operator of a community care facility, nor the employee of an operator of a residential care facility for the elderly; and 6) I am over 18 years of age.

WITNESS #1

____

Signature of Witness #1 Date

____

Printed Name of Witness #1 Phone Number

WITNESS #2

____

Signature of Witness #2 Date

____

Printed Name of Witness #2 Phone Number

One of the witnesses also must 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 Healthcare 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 #1 or #2 Date

____

Printed Name of Witness #1 or #2 Date

Special Witness Requirement

Note: For nursing home or skilled nursing facility patients only, a signature from a patient advocate or ombudsman is required in addition to completing either Page 13 or Page 14.

If you are **not** a nursing home patient or skilled nursing facility patient, you may skip this section.

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.

____

Signature of Patient Advocate or Ombudsman   Date

____

Printed Name of Patient Advocate or Ombudsman   Phone Number

Extra pages

Additional Resources

To sign up for the free Advance Care Planning Class, call 800-700-6424.

Cedars-Sinai Supportive Care Medicine, 310-423-9520
Cedars-Sinai's Supportive Care Medicine (SCM) team helps inpatients and outpatients who are facing life-limiting or advanced illness to achieve the best possible quality of life, and also provides support for families. SCM clinicians are experts in managing a full range of symptoms, both physical and psychological; they are also specifically trained to help with Advance Care Planning and Advance Healthcare Directives.

Cedars-Sinai Spiritual Care, 310-423-5550; cedars-sinai.org/spiritualcare
Members of the Cedars-Sinai Spiritual Care Department offer spiritual care services to Cedars-Sinai patients and their loved ones. Chaplains are available to visit patients and help work through difficult issues related to end-of-life decisions and care.

Cedars-Sinai Center for Healthcare Ethics, 310-423-9636; cedars-sinai.org/ethics
For patients hospitalized at Cedars-Sinai, the center offers clinical ethics consultation. The aim is to help patients, family members, physicians and other members of the patient care team examine and discuss pertinent ethical values and goals.

Cedars-Sinai Social Work
Inpatient: 310-423-4446 | Outpatient: 310-248-8311

The following are websites that provide information on advance healthcare planning:

- Advance Health Care Directive Registry—California: sos.ca.gov/registries/advance-health-care-directive-registry
- Aging With Dignity: agingwithdignity.org
- American Hospital Association: putitinwriting.org
- California Medical Association: cmanet.org
- Caring Connections: caringinfo.org
- Coalition for Compassionate Care of California: coalitionccc.org and capolst.org (POLST forms in English and other languages)
- Hospice Association of America: hospice.nahc.org
- Donate Life California—Organ and Tissue Donor Registry: donatelifecalifornia.org
- U.S. Department of Veterans Affairs: losangeles.va.gov/patients/advance.asp

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