Menlo Medical Clinic
Affiliated with Stanford Hospital & Clinics

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

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 "Power of Attorney" for health care. If you have a DPOA dated prior to 1992, please take a few minutes to update by using this updated form and discuss with your primary care physician, family members, loved ones and friends.

If you have a complaint specifically about Menlo Medical Clinic's provision of information on advance directives, you may also contact:

Department of Health Services,
Licensing and Certification Division
1 Almaden Blvd., Floor 9
San Jose, CA 95113
(408) 277-1784
(408) 277-1032 (FAX)

If you are a Medicare patient with any complaints about Menlo Medical Clinic's provision of information on advance directives, you may also call:

Medicare Hotline: 1 (800) 633-4227 (1-800-Medicare)

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PART I

POWER OF ATTORNEY FOR HEALTH CARE

Part 1 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. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably capable 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 you agent is related to you or is a co-worker.)

A. DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

____

(Name of individual you choose as your agent)

____

(Address) (City), (State) (Zip Code)

____

(Home Phone) (Work Phone) (Cell Phone)

First Alternate Agent Option: If I revoke my agent's authority, or if my agent is not willing, able, or reasonably available to make a health care decision as my first alternate agent:

____

(Name of individual you choose as your agent)

____

(Address) (City), (State) (Zip Code)

____

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(Home Phone) (Work Phone) (Cell Phone)

Second Alternative Option: If I revoke my agent's authority, or if my agent is not willing, able, or reasonably available to make a health care decision as my second alternate agent

____
(Name of individual you choose as your agent)

____
(Address) (City), (State) (Zip Code)

____
(Home Phone) (Work Phone) (Cell Phone)

B. AGENT"S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all forms of health care to keep me alive, except as I state here:

____
____
____
____
____
____
____
____
____
____
____
____

(Add additional sheets if needed)

C. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box ❒ my agent's authority to make health care decisions for me takes effect immediately.

D. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part II of this form, and my

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other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extend known to my agent.

E. AGENT'S POST-DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, excepts as I state here, or in Part III of this form:

____

____

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(Add additional sheets if necessary)

F. NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by the court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agent(s) whom I have named, in the order designated.

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PART II

INSTRUCTIONS OF HEALTH CARE

Part II lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Your choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive and also as the provision of pain relief. There is space available for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part II of this form.

If you fill out this part of the form, you may strike any wording you do not want.

A. END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

❒ (a) **Choice Not to Prolong Life**
I do not want my life to be prolonged if: 1) I have an incurable and irreversible condition that will result in my death within a relatively short time; 2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or 3) the likely risks and burdens of treatment would outweigh the expected benefits,

or,

❒ (b) **Choice to Prolong Life**
I wish my life to be prolonged as long as possible within the limits of generally accepted health care standards.

B. RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

____

____

____

(Add additional sheets if necessary)

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C. OTHER WISHES/INDIVIDUAL HEALTH CARE DIRECTIVE: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

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(Add additional sheets if necessary)

Additional Pages: I have added ______ page(s) of specific health care instructions to this directive which I have signed and dated each page on the same date I have signed this directive.

____
Patient's Signature

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PART III
DONATION OF ORGANS AT DEATH (OPTIONAL)

Be sure to communicate your intensions to your family members, loved ones and physician(s).

Part III of this form lets you decide your intention to donate your bodily organs and tissues following your death.

DONATION:

A. Upon my death (mark applicable box)

❒ (a) I give any needed organs (e.g., kidneys, liver, heart, lungs, pancreas, spleen) tissues (e.g., corneas, heart vlave, skin, bones), or parts,

or,

❒ (b) I give the following organs, tissues, or parts only

____

____

____

____

____

____

____

____

AND,

PURPOSE:

(c) strike any of the following you do **NOT** want)

- Transplant
- Therapy
- Research
- Education

____

Patient's Signature

For more information on organ and tissue donation in California, contact the California Transplant Donor Network at www.ctdn.org or phone 1-888-570-9400.

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PART IV

PRIMARY PHYSICIAN (OPTIONAL)

Part IV of this form lets you designate a physician to have primary responsibility for your health care.

A. I designate the following physician as my primary physician:

____
(Name of Physician)

____
(Address, City, State, Zip)

____
(Phone)

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PART V

SIGNATURE AND WITNESS SECTION

Part V of this form is the signature and witness signature(s) and notary section.

A. EFFECT OF COPY: A copy of this form has the same effect as the original
.
B. SIGNATURE: Sign and date form here:

______________________________ ______________
(Sign Your Name) (Date)

____
(Print Your Name)

____
(Address, City, State, Zip)

C. STATEMENT OF WITNESSES:
I declare under penalty of perjury under the laws of California

1) that the individual who signed or acknowledged 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 agency by this advance directive, and
5) that I am not the individual's health care provider, an employee of the individual's healthcare 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.

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FIRST WITNESS:

(Sign Your Name) (Date)

(Print Your Name)

(Address, City, State, Zip)

SECOND WITNESS

(Sign Your Name) (Date)

(Print Your Name)

(Address, City, State, Zip)

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D. ADDITIONAL STATEMENT OF WITNESSES:

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.

____ ____________________
(sign your name) (date)

____
(print your name)

____
(address, city, state, zip)

E. CERTIFICATE OF ACKNOWLEGEMENT OF NOTARY PUBLIC

State of California)
) ss.
County of ____________)

On this _____________, before me, _____________________________________ personally

appeared ______________________________ ______________________________________
(date) (name and title of officer)

____
(signature of notary public)

personally known to me (or 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 his/her/their signatures(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

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WITNESS my hand and official seal.

_____________________________________ Notary Seal

EVIDENCE OF IDENTITY: A current California driver's license or identification card or US Passport.

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Part VI

SPECIAL WITNESS REQUIREMENT

Part VI of this form is a special witness requirement to be completed 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 patient s whose primary need is for availability of skilled nursing care on an extended basis.

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.

You should keep the completed original and give copies of the completed original to the following:

1. your agent and alternate agents
2. your physician(s)
3. members of your family and others who might be called in the event of a medical emergency
4. any hospital or other health facility where you receive treatment.

Instruct your agent(s), family, and friends to provide a copy of your directive to your physician(s) or emergency medical personnel on request.

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CONTACT LIST FOR PEOPLE WHO HAVE A COPY OF MY ADVANCE HEALTH CARE DIRECTIVE

You should give copies of your completed Advance Health Care Directive form to the following people:

(1) Your agent and alternate agent(s),
(2) Your physician(s) and health plan,
(3) Your family members or anyone else who is likely to be called if there is a medical emergency, and
(4) Any hospital or other health facility where you receive treatment.

You should also take a copy of the Directive with you if you are going to be admitted to a hospital, nursing home, or other health care facility.

This Contact List will help you to remember the people and health providers who have copies of your Directive so that you can contact them with updated information if you decide to revoke or change it. Remember to bring a copy of this Contact List with you if you are going to be admitted to a hospital, nursing home, or other health care facility.

Date of my Advance Health Care Directive: ____________________________.
(date)

PEOPLE WHO HAVE A COPY OF MY ADVANCE HEALTH CARE DIRECTIVE

Name: ____________________________ Name: ____________________________

Address: __________________________ Address: __________________________

__________________________ __________________________

Phone(s): ________________________ Phone(s): ________________________

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Name: ______________________________

Fax: ______________________________

Email: ______________________________

Name: ______________________________

Address: ______________________________

Name: ______________________________

Fax: ______________________________

Email: ______________________________

Name: ______________________________

Address: ______________________________

Name: ______________________________

Phone(s): ______________________________

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Phone(s): ______________________________

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Name: ______________________________

Address: ______________________________

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Phone(s): ______________________________

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Fax: ______________________________

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ADVANCE HEALTH CARE DIRECTIVE
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Name: ______________________________

Address: ___________________________

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Phone(s): __________________________

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Fax: _______________________________

Email: _____________________________

Name: ______________________________

Address: ___________________________

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Phone(s): __________________________

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Phone(s): __________________________

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Name: ______________________________

Address: ___________________________

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Phone(s): __________________________

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Fax: _______________________________

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