

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 with:

☐ Doctor copy ☐ Family Copy ☐ Agent Copy

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
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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	
Address	City	State	Zip Code
Witness #2 Print Name	Witness Signature	Date	
Address	City	State	Zip Code

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.

Your Advance Health Care Directive Your Health Your Future

*This is a gift to your family and friends so that they won't have to guess
if you are no longer able to speak for yourself.*

Why do I need an Advance Health Care Directive?

- Medical technology makes it possible for a person with little or NO hope of recovery to be kept alive for months or years.
- NOW is the time to tell the people in your life what is important to you.
- If you don't have an Advance Healthcare Directive, and even one person interested in your care disagrees, your doctor may not be able to honor your wishes for end-of-life care.

What should be in my Advance Health Care Directive?

- Whether or not to prolong your life as long as possible within the limits of health care standards.
- Your wishes and instructions whether or not you would like machines to breathe for you or feed you through a tube.
- Wishes to have pain and discomfort alleviated.

Who do I use to speak on my behalf (as my Agent)?

- The person(s) that you designate as your Agent has the right to accept or refuse ANY kind of medical care, testing and/or access to any medical records.
- This person can be a spouse, family member, trusted friend or clergy member.
- The Agent cannot be an owner or employee of a health care facility where you are receiving care unless they are related to you.

What are your wishes for comfort care?

- You can indicate if you would like medicine for pain or discomfort.
- You can designate where you would like to spend your last days (for example, home, hospital, or hospice) and give spiritual, ethical or religious instructions.

How can I ensure that my advance directive is honored?

Share copies and talk with people who will be involved in your care. Ask your doctor to make your advance directive part of your medical records.

Instructions for Advance Health Care Directives

(In accordance with the Uniform Health Care Decisions Act)

You may add information or make any changes you wish to this form, or use another form. If specific areas are left blank we will assume that your agent is aware of your wishes and will therefore represent you in any situation. If you need additional assistance please contact numbers included below. You do not need an attorney to complete this form.

PART 1: Individual Instructions

Give instructions to your family, friends and doctors about any aspect of your health care. Check only boxes in each category that you agree with and cross out those that do not apply.

PART 2: Health Care Power of Attorney

Select one or more persons to be your agent and to make health care decisions should you become unable to make them yourself.

PART 3: For the Advance Health Care Directive to be valid you must sign it:

- **Before two adult witnesses who are personally known to you and who are present when you sign. These witnesses must sign and date the document.**
They cannot be health care providers, employees of a health care facility, or the person you choose as an agent. One of the two persons cannot be related to you or have inheritance rights.

OR

- **Before a notary public in the state**
If you do not have two witnesses, your Advance Health Care Directive must be notarized.

You have the right to revoke or change your Advance Health Care Directive at any time.
(Be sure to tell your agent and doctor if changes are made.)

Who can help me complete my Advance Health Care Directive?

- Talk to your health care provider
- Legal Aid Society – Oahu (808) 536-4302 or Neighbor Islands 1-800-499-4302 or www.legalaidhawaii.org
- University of Hawaii Elder Law Program for legal issues or concerns - (808) 956-6544 or www.hawaii.edu/uhelp
- Kauai: Senior Law Program - (808) 246-8868 or www.seniorslawprogram.org

Additional Information and Resources:

- Executive Office on Aging, State of Hawaii for general information - (808) 586-0100
- Kokua Mau Hawaii's Hospice and Palliative Care Organization – (808) 585-9977 or www.kokuamau.org
- Legacy of Life Hawaii (formerly Organ Donor Center of Hawaii) – (808) 599-7630 or www.legacyoflifehawaii.org