Hawaii Pacific Health
Kapi'olani • Pali Momi • Straub • Wilcox

ADVANCE HEALTH CARE DIRECTIVES

Patient's Full Name: _____
Last First M.I.

Date of Birth: _____ Social Security Number: _____/_____/_____
Month – Day - Year

Part One: Instructions for Health Care

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:

Check ONE ONLY – A or B

☐ **A. Choice To Prolong Life:**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards that apply to my condition.

☐ **B. Choice NOT To Prolong Life:**
I have an incurable and irreversible condition that will result in my death within a relatively short time; OR I become unconscious and, to a reasonable medical certainty, I will not regain consciousness; OR the likely risk(s) and burden(s) of treatment would outweigh the expected benefits.

Artificial Nutrition and Hydration (food and fluids):

☐ **I do want** artificial nutrition and hydration (regardless of my choice above as A or B).

☐ **I do not want** artificial nutrition and hydration (regardless of my choice above as A or B).

Relief from Pain:

☐ **I do want** treatment to relieve my pain or discomfort (even if it hastens my death).

☐ **I do not want** treatment to relieve my pain or discomfort (even if it hastens my death).

Other Wishes:

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, including ethical, religious, or spiritual instructions, please do so here:

I, _____, **direct that:** _____
(Print Full Name)

_____

_____

_____

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Part Two: Health Care Power of Attorney

☐ **I Choose NOT To Designate An Agent**
☐ **I Choose To Designate An Agent**

Designation of my Agent:
I designate the following individual as my Agent to make health care decisions for me:

_____
(Name of individual I choose as my Agent – Print Full Name) (Relationship)

_____
(Address) (City) (State) (Zip Code)

_____
(Home Phone Number) (Work Phone Number) (Pager Number, Cellular Number, or E-Mail Address)

☐ **I Choose NOT To Designate An Alternate Agent**
☐ **I Choose To Designate An Alternate Agent**

Designation of my Alternate Agent:
I designate the following individual as my Alternate Agent to make health care decisions for me:

_____
(Name of individual I choose as my Agent – Print Full Name) (Relationship)

_____
(Address) (City) (State) (Zip Code)

_____
(Home Phone Number) (Work Phone Number) (Pager Number, Cellular Number, or E-Mail Address)

When My Agents Authority Becomes Effective

☐ My Agent's authority to make health care decisions for me takes effect immediately.

☐ My Agent's authority becomes effective when my primary physician determines that I am unable to make health care decisions.

Agent's Obligation

My agent shall make health-care decisions for me accordance with this power of attorney for health care, any instructions I give in Part 1 of this form, and my 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 extent known to my agent.

Agent's Authority

My Agent is authorized to make all health care decisions for me except: _____

_____

_____

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Part Three: Donations of Organs at Death (Optional)

Upon My Death: (mark applicable boxes):

☐ I give any needed organs, tissues, or parts, OR

☐ I give the following organ(s), tissue(s), or parts only: _____

_____

☐ My gift is for the following purposes: (strike any of the following you do not want)

(i) Transplant
(ii) Therapy
(iii) Research
(iv) Education

Signature: (sign and date form here)

By executing this Advance Health Care Directive, I understand that other prior Advance Health Care Directive(s) are hereby revoked.

_____ _____
Signature Date

_____
Print Your Name

_____ _____ _____ _____
Address City State Zip Code

Effect of Copy
A copy of the form has the same effect as the original.

This Advance Health Care Directive will not be valid for making health care decisions unless it is either:

Option A: Signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

OR

Option B: Acknowledged before a Notary Public in the state.

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OPTION A OR OPTION B

OPTION A:

Witness 1:
I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this Advance Health Care Directive in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as the agent of this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon death of the principal under a will now existing or by operation of the law.

_____ _____
Signature of Witness 1 Date

_____ _____
Print Full Name Telephone#/Cellular #/E-Mail Address

_____
Address City State Zip Code

Witness 2:
I declare under penalty of false swearing pursuant to section 710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this Advance Health Care Directive in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as the agent of this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

_____ _____
Signature of Witness 2 Date

_____ _____
Print Full Name Telephone#/Cellular #/E-Mail Address

_____
Address City State Zip Code

OPTION B:

State of _____
City and County of _____

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.

Notary Seal

_____ My Commission Expires: _____
(Signature of Notary Public)

_____
(Print Name)