Advance Health Care Directives

THE QUEEN'S MEDICAL CENTER

Advance Health Care Directive

At The Queen's Medical Center we support your right to make decisions regarding your health care through this written document known as an Advance Health Care Directive. This document will assist you in answering the question of how health care decisions will be made for you if you are no longer able to decide for yourself.

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. Discuss these important decisions with your family and doctor.

The best time to discuss and complete an Advance Health Care Directive is before you are admitted to a hospital, or even better, now. This gives you time to think about your decisions, discuss them with your family, friends, and doctor, and make the necessary arrangements for witnesses or a Notary Public.

Part 1 of this form allows you to give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive. These include artificial nutrition and hydration (tube feeding and IV fluids) as well as pain relief medication.

Part 2 of this form is a Health Care Power of Attorney. Part 2 allows you to name another individual as your agent to make health care decisions for you if you become incapable of making your own decision, or if you want someone else to make these decisions for you now, even though you are still capable. You may name an alternate agent to act for you if your first agent is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution.

Part 3 of this form allows you to make your wishes known regarding organ and/or tissue donations.

To complete this form:

Complete Part 1, Part 2 and Part 3, sign and date the form at the end and have the form witnessed by one of the following methods:

- Arrange for two witnesses. Each witness should be personally known to you but cannot be a health care provider, an employee of a health care provider or facility, or your agent. At least one of the witnesses cannot be your relative or entitled to a portion of your estate under your will.

- OR -

- Arrange for a Notary Public to notarize the document.

Process your completed documents as follows:

- Keep the original documents in a safe location where you keep other important papers.
- Give a copy to your primary care physician for his/her records.
- Mail a copy to:

  The Queen's Medical Center
  Medical Records
  1301 Punchbowl Street
  Honolulu, HI 96813
- You should also make a copy for your spouse, a close family member, and the agent(s) you have appointed to make decisions for you.

Whenever you are admitted to a hospital, a skilled nursing facility or a home care agency, you will be asked if you have an Advance Health Care Directive.

- This gives you the opportunity to review your Advance Health Care Directive to make sure it expresses your current wishes.

- It is important to provide notice of any change in your wishes to your health care provider. You have the right to revoke or replace this Advance Health Care Directive form at any time. If you change or replace the Advance Health Care Directive, please mail a copy of the revised document to The Queen's Medical Center. (at the above address)

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Patient's Full Name

Social Security Number

Date of Birth

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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 - 1A or 1B

❑ **1A. Choice Not To Prolong Life If:**

- 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 degree of medical certainty, I will not regain consciousness, OR
- The likely risks and burdens of treatment would outweigh the expected benefits.

❑ **1B. 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.

Artificial Nutrition and Hydration:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in question 1A/1B unless I check one of the following:

❑ **I do not** want artificial nutrition and hydration regardless of my condition and regardless of the choice I have made in question 1A/1B.

❑ **I do** want artificial nutrition and hydration regardless of my condition and regardless of the choice I have made in question 1A/1B.

Relief from Pain:

❑ **I do not** want treatment to alleviate pain or discomfort even if it hastens my death.

❑ **I do** want treatment to alleviate 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, you may 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)

(pager, cellular or e-mail address) (home phone) (work phone)

☐ **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)

(pager, cellular or e-mail address) (home phone) (work phone)

☐ **I choose not to designate a Second Alternate Agent**

☐ **I choose to designate a Second Alternate Agent**

Designation of my Second Alternate Agent:

I designate the following individual as my Second 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)

(pager, cellular or e-mail address) (home phone) (work phone)

When My Agents Authority Becomes Effective

☐ My agents authority to make health care decisions for me takes effect immediately.

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

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Part Two Continued

Agent's Obligation

My agent shall make health care decisions for me in accordance with this Health Care Power of Attorney, 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 healthcare decisions for me, except as I state here:

_____

_____

Part Three: Donation of Organs/Body at Death (Optional)

Upon my death: Mark applicable box(es).

- ☐ (a) I give any needed organs, tissues, or parts, OR
- ☐ (b) I give the following organs, tissues, or parts only:

  _____

- ☐ (c) My gift is for the following purposes: (Strike through any of the following you do not want)
  - (i) Transplant
  - (ii) Therapy
  - (iii) Research
  - (iv) Education
- ☐ (d) I give my body to the John A. Burns School of Medicine for its research and education purposes. (Obtain information/forms from the school)

Principal Signature: Sign and date the form here:

_____
(signature of principal - print full name) (date)

_____
(address) (city) (state) (zip code)

_____
(pager, cellular or e-mail address) (home phone) (work phone)

Effect of Copy

A copy of this 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.

Option B: Acknowledged before a notary public in the state.

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Option A or Option B

Option A: Statement of Witnesses

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 power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence,

1) that I am not the person appointed as agent by this document,
2) and that I am not a health care provider, nor an employee of a health care provider or facility,
3) I am not related to the principal by blood, marriage, or adoption,
4) and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

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 power of attorney 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 agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

_____

(print full name / signature of witness 1) (date)

_____

(address) (city) (state) (zip code)

_____

(pager, cellular or e-mail address) (home phone) (work phone)

_____

(print full name / signature of witness 2) (date)

_____

(address) (city) (state) (zip code)

_____

(pager, cellular or e-mail address) (home phone) (work phone)

Option B: Notarization (to be completed by a Notary Public)

State of _____

City & County of _____

Subscribed, sworn to, acknowledged before me, _____,

the undersigned Notary Public, by _____, the declarant

on this _____ day of _____, _____.

Signed: _____
Notary Public, State of Hawaii

My commission expires: _____