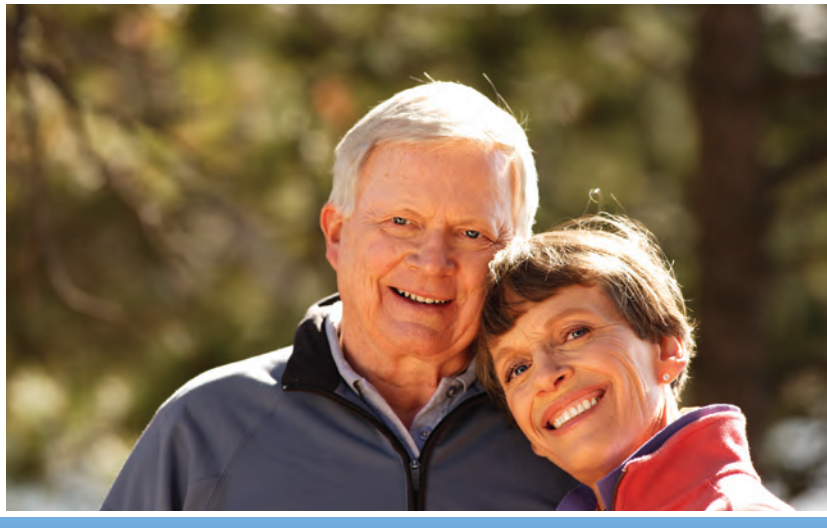
eAdvance Health Care Directive



LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

KAISER PERMANENTE®

1-B Full name: _____
Medical Record #: _____

1-A Introduction

This Advance Health Care Directive allows you to share your values, your choices, and your instructions about your future health care. This form may be used to:

- Name someone you trust to make health care decisions for you (your health care agent), OR
- Provide written instructions about your health care, OR
- Both name a health care agent AND provide written instructions for health care.

Part 1 allows you to name a health care agent.

Part 2 gives you an opportunity to share your values and what is important to you.

Part 3 allows you to give written instructions about your health care.

Part 4 allows you to guide your agent's decision making by stating your hopes and wishes.

Part 5 allows you to make your Advance Health Care Directive legally valid in the State of Colorado.

Part 6 prepares you to share your wishes and this document with others.

You are free to complete or modify all or any part of this form, or use a different form.

This Advance Health Care Directive will replace any Advance Health Care Directive you have completed in the past. In the future, if you want to cancel or change your named agent, complete a new document or inform your health care provider in person.

Full name: _____

Medical Record number: _____ Date of birth: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Full name: _____
Medical Record #: _____

Part 1. My Health Care Agent

2-A *Selecting a health care agent:*
Choose someone who knows you well, who you trust to honor your views and values, and who is able to make difficult decisions in stressful situations. Once you have selected your health care agent, take the time to discuss your views and treatment goals with that person. Make sure they are willing to act as your decision maker.

If I am unable to communicate my wishes and health care decisions, or if my health care provider has determined that I am not able to make my own health care decisions, I choose the following person(s) to represent my wishes and make my health care decisions.

2-B My health care agent must make health care decisions that are consistent with my instructions in this document and my known desires. If my agent does not know my wishes, my agent must make health care decisions that he or she believes to be in my best interest, considering what he or she knows about my personal values.

This form does not give my health care agent the authority to make financial or other business decisions.

My primary (main) health care agent is: 2-C

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

Need additional assistance?
kp.org/lifecareplan

Full name: _____
Medical Record #: _____

If I cancel my primary health care agent's authority, or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name the individuals below as my first and second alternate agents.

First alternate health care agent: 3-A

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

If I cancel my agent's authority, primary or first alternate, or if neither is willing, able, or reasonably available to make a health care decision for me, I name the individual below as my second alternate agent.

Second alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

Powers of my health care agent: 3-B

Unless I limit my agent's authority, my health care agent has all of the following powers: when I am unable to speak for myself or make my own decisions:

A. Make choices for me about my health care. This includes decisions about tests, medicine, and surgery. It also includes decisions to provide, not provide, or stop all forms of health care to keep me alive, including artificial nutrition (food) and hydration (water) and cardiopulmonary resuscitation.

B. Review and release my medical records as needed to make decisions.

C. Decide which physician, health providers, and organizations provide my medical treatment.

D. Arrange for and make decisions about the care of my body after death (including autopsy).

Full name: _____
Medical Record #: _____

Please provide any additional comments or restrictions to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify decisions you would not want your agent to make.) Attach additional page(s) if necessary.

4-A

Additional powers of my health care agent instructions:

Check the box below, if you want your agent to have the following powers.

4-B

❑ I want my agent to continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership has been completed.

❑ I want my agent to immediately begin making health care decisions for me even if I am able to decide or speak for myself.

Need additional assistance?
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Full name: _____
Medical Record #: _____

Part 2. My Values 5-A

I want my agent and loved ones to know what matters most to me, so that they can make decisions about my health care that match who I am and what is important to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, who I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

1. If I were having a good day, I would be doing the following:

5-B

2. What matters most to me is:

3. Life would no longer be worth living if I were not able to:

5-C

4. Religious or spiritual traditions:

5-D I am of the faith, and am a member of (faith/spiritual community) in (city) , (phone #) . I would like my agent to notify them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

❑ I have no specific religious or spiritual traditions.

Full name: _____
Medical Record #: _____

Part 3. My Health Care Instructions

If you choose not to provide written instructions, your health care agent will make decisions based on your spoken directions. If your directions are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.

In the situation below, we ask you to consider a sudden unexpected event that leaves you unable to communicate for yourself.

I ask that my health care agent represent my choices as detailed below, and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are unable to make decisions on my behalf, this document represents my wishes.

6-A

1. Treatments to prolong life

Consider the following situation:

You have a sudden accident or stroke.

6-B Doctors have determined you have a brain injury, leaving you unable to recognize yourself or loved ones. The doctors have told your agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine), or a feeding tube, etc., are required to keep you alive. In this situation what would you want?

I would want to be kept comfortable and:

Choose One

- ☐ I would want to STOP life-sustaining treatment. I realize this would probably lead me to die sooner than if I were to continue treatment.
- ☐ I would want to continue life-sustaining treatments.

Please provide any additional instructions about life-sustaining treatments. For example, you may want to state a specific time period that you would want to be kept alive if there were no improvement to your health.

6-C

Full name: _____
Medical Record #: _____

2. CPR (Cardiopulmonary resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

7-A You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* If you would like additional information about CPR, please request the brochure, called **CPR: My Choice**.

If you are certain do not want CPR, please discuss other documents you may want to complete with your physician.

In the event that your heart and breathing stop, what would you want?

Choose One

- ☐ I always want CPR attempted.
- ☐ I never want CPR attempted, but rather, want to permit a natural death.
- ☐ I want CPR attempted unless the doctor treating me determines any of the following:
  - I have an incurable illness or injury and am dying; or
  - I have no reasonable chance of survival if my heart or breathing stops; or
  - I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause significant suffering.

Need additional assistance?
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*Research shows that if you are in a hospital and get CPR, you have a 24.8% chance of surviving and leaving the hospital alive (statistic is overall, for all hospitalized adults). CPR Facts and Stats. CPR & First Aid Emergency Cardiovascular Care. Retrieved August 29, 2017 from:
http://cpr.heart.org/AHAECC/CPRAndECC/General/UCM_477263_Cardiac-Arrest-Statistics.jsp

Full name: _____
Medical Record #: _____

Part 4. My Hopes and Wishes (Optional)

1. **As I'm nearing my death, I want my loved ones to know I would appreciate having the following (prayers, rituals, music) and where I prefer to die:**

8-A

2. **Other wishes/instructions**:

Organ donation:

If you are interested in donating organs when you die, you can declare your donor status when getting or renewing a driver's license by registering through the donor registry found at **donatelifecolorado.org**. No form is required for organ donation. 8-B

Full name: _____
Medical Record #: _____

Part 5. Making This Document Legally Valid

Although not required by Colorado law, it is recommended to sign this document before a Notary Public for full legal effect. If you want this document to serve as your Advance Directive, it must also be signed by two witnesses. Follow the steps outlined below in the order in which they are listed: 9-A

1. Choose

Two Witnesses **AND/OR** **Notary Public**

- Witnesses cannot be someone who provides health care for you or works for an organization which provides your health care or someone who would inherit money or property from you.
- Your primary and alternate agents cannot sign as witnesses.
- When you are with your witnesses, sign or acknowledge your signature.
- Witnesses will sign on page 10.
- You will sign on page 12.

9-B

- Do NOT sign this document until you are with a Notary Public.
- Notary Public will sign on page 11.
- You will sign on page 12.

Full name: _____
Medical Record #: _____

Statement of Witnesses

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of Colorado:

- that the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence,
- that the individual signed or acknowledged this Advance Health Care Directive in my presence,
- that the individual appears to be of sound mind and under no duress, fraud, or undue influence, and
- that I am not appointed as an agent by this Advance Health Care Directive.

Witness Number One: 10-A

Print full name: _____

Address: _____

Signature: _____ Date: _____

Witness Number Two:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Full name: _____
Medical Record #: _____

Notary Public

11-A State of Colorado

County of [ ]

on [ ] before me, [ ],
Date Name and Title of Notary

personally appeared [ ]
Name of Signer

who provided to me satisfactory evidence to be the person whose name is subscribed to this document and acknowledged to me that he/she executed it.

I certify under PENALTY OF PERJURY under the laws of the State of Colorado that the foregoing paragraph is true and correct.

11-B WITNESS my hand and official seal. Signature

(Seal) _____

Full name: _____
Medical Record #: _____

MY SIGNATURE

My name printed: _____

12-A **My Signature:** _____ **Date:** _____

If you are physically unable to sign, any person qualified to act as a witness may sign for you in your presence and at your direction.

Full name: _____
Medical Record #: _____

Part 6. Next Steps

Now that you have completed your Advance Health Care Directive, you should also take the following steps.

Discuss:

13-A ❑ Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to perform this important job for you in the future.

❑ Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.

Give copies:

13-B ❑ Give your health care agent a copy of your Advance Health Care Directive.

❑ Give a copy of your Advance Health Care Directive to your doctor. Discuss it with your doctor to ensure your wishes are understood.

❑ Make a copy for yourself and keep it where it can be easily found.

Take with you:

❑ I f you go to a hospital or nursing home, take a copy of your Advance Health Care Directive and ask that it be placed in your medical record.

❑ Take a copy with you any time you will be away from home for an extended period of time.

Review regularly:

❑ Review your health care wishes whenever any of the "Five D's" occur:

Decade – when you start each new decade of your life.

Death – whenever you experience the death of a loved one.

Divorce – when you experience a divorce or other major family change.

Diagnosis – when you are diagnosed with a serious health condition.

Decline – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

13-C **Changing your Advance Health Care Directive:**
If your wishes or health care agent change, please notify your provider or fill out a new Advance Health Care Directive. Tell your agent, your family, and anyone else who has a copy, and provide a copy to Kaiser Permanente.

Full name: _____
Medical Record #: _____

Copies of this document have been given to:

- Primary (Main) Health Care Agent

  Full name: _____

  Telephone: _____

- Alternate Health Care Agent #1

  Full name: _____

  Telephone: _____

- Alternate Health Care Agent #2

  Full name: _____

  Telephone: _____

- Health Care Provider/Clinic

  Name: _____

  Telephone: _____

- Others:

  Name: _____

  Telephone: _____

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Adapted for Kaiser Permanente Colorado with permission. Department of Senior Programs. KPID CO1501 0015 (1.2019)

Instructions

1-A Learn more about our approach to Life Care Planning.

1-B Please remember to write these items on every page:

- Your name.
- Your medical record number, which is found on your blue Kaiser insurance card.

2-A What are the qualities you should look for in agent? Learn how to choose an agent.

2-B Learn more about what is an agent and their responsibilities.

2-C Some people don't have anyone in mind to be their agent. Learn about Life Care Planning without an agent.

3-A An alternate agent would be needed if your primary agent is not available. Learn more about agents.

3-B Video: What I might consider when choosing my agent.

4-A This space may be used for any instructions related to agents and their powers. If you have a family member who has beliefs about these topics that are significantly different from yours, you may decide to exclude this person from being involved in decision-making, even informally.

4-B Learn more about these situations.

5-A In a serious medical situation, where the outcome is uncertain, your agent may look to this section for guidance. You'll be doing your agent a favor by providing rich detail here.

5-B For further guidance, read your values are at the center of your life care plan.

5-C Situations where values matter.

5-D If you are part of a faith community, please add in details of how we may contact them.

6-A Should you ever be in a similar situation, it would be valuable for your agent to know your opinions about life sustaining treatment.

6-B Video: Get more details about this brain injury scenario.

6-C Video: Learn more accepting life sustaining treatments for a specific time period, in this scenario.

7-A CPR can save lives, but it's not as effective most people think. Read a discussion about CPR.

8-A Sometimes, our values inform not only what we want, but of what we don't want. If you have some thoughts about how you would ideally like to die, please add them here.

8-B If you wish to donate organs or tissues be sure your agent and family are aware of this. For more information about organ and tissue donation please visit DonorAlliance.org

9-A Learn more about making this document legally valid.

9-B If you are using Witnesses and/or Notary you'll want to wait to sign in their presence.

10-A Learn more about making this document legally valid.

11-A Learn more about making this document legally valid.

11-B If you are using a Notary Public you'll want to sign in their presence.

12-A Remember if you are using Witnesses and/or Notary you'll want to wait to sign in their presence.

13-A Learn more about sharing your values with your agent.

13-B If you have a scheduled doctor appointment, you may hand deliver a copy to your doctor. Alternately you can mail to your local Kaiser Permanente Medical Office (attention to your doctor). Click here for more information on where to mail it to.

13-C Read more: With whom should you share your Life Care Plan?