San Joaquin Coalition for Compassionate Care

My Values Worksheet

I want my agent and loved ones to know what matters most to me. I'd like to tell you some things that give me a quality of life. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me. My hope is that in giving you insight into my life values, this will make it easier for you and will help guide you in making medical decisions for me that coincide with what matters most to me.

1. If I were having a meaningful day, it would bring me joy to be doing this and/or talking to:
   (What routines do you enjoy doing? Hobbies or associations you are a part of? etc.)

   _____

   _____

2. These are aspects of my life that I value the most and would like to continue to be able to do:
   (This may include how self-sustaining you need to be, the activities that you enjoy, your ability to communicate and interact with those you love, etc.)

   _____

   _____

3. These are my cultural, religious or spiritual beliefs that may have an impact on my medical decision making:
   (Include, how important is it to you that the type of treatment and care you receive align with your faith system?)

   _____

4. These are future events, milestones or occasions that I would like to be present for:
   (If your time was limited, which event(s) would be of the highest priority for you to experience?)

   _____

   _____

   (Add and attach additional pages if needed)

5. This is a lesson that I have learned from the experience of a family member or friend who was seriously ill or injured:
   (What were the positives or negatives? Did you agree with the type of care that was decided on or were there things you wish would have been done differently?)

   _____

   _____

6. These are the medical treatments that I have seen others experience that I know that I would or would not want for myself:
   (Such as CPR, breathing assistance, feeding tubes, etc.)

   _____

   _____

7. These are my fears surrounding end-of-life and death:
   (Such as invasive treatments, not being able to be present for family, being in pain, not being alert, etc.)

   _____

   _____

8. This is the type of care I would want to receive during this season of my life:
   (Would you like to be pain free, sedated, be lucid, be kept comfortable, etc.)
   _____
   _____

9. These are the individuals I would like to be present during my final days?
   (Spouse, children, family members, friends, doctor, etc.)

   _____
   _____

10. This is where I want to spend my final days?
    (At home, in the hospital, at a care facility, etc.)

    _____
    _____

    (Add and attach additional pages if needed)

San Joaquin Coalition for Compassionate Care

Advance Health Care Directive Directions

Part A. My Health Care Agent.

In most cases, your Healthcare Agent can be anyone that the law considers to be an adult, but with these exceptions:

- Your Healthcare Agent can't be your treating doctor or the doctor's staff (to prevent potential conflicts of interest).
- Your Healthcare Agent can't be the owner/operator or employees of the medical facility, nursing home, or hospice where you're being treated.

Before you choose your Healthcare Agent, it's important to think about a couple of things:

- Can this person be at the hospital to assess the situation firsthand and talk with your doctors?
- Can this person handle the pressure of potentially having to make very difficult medical decisions for you during a time of great stress?

You should speak with anyone you're considering to be your Healthcare Agent to make sure that the person is comfortable with the responsibility. If you decide to additionally name alternates, be sure to speak with them as well. You will need to talk about your goals, preferences and priorities in cases of emergency or critical care, advanced illness, or end-of-life situations, and your thoughts about quality of life, so that the person you choose to be your Healthcare Agent (and Alternates) will know how you'd like medical treatment decisions made on your behalf.

Part B. Instructions for Health Care.

Part B of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part C. Donations of Organs at Death

Here you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. If you choose to be an organ or tissue donor, you may also specify the purposes for which you choose their use. If you choose not to be an organ or tissue donor, you also have that right.

Part D. My Treating Physician (Optional)

You have the option on this form to designate a physician to have primary responsibility for your health care.

Part E. Signature

After completing this form, sign and date the form. Part E.3 is for two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any Healthcare Agents you have named; also keep a copy readily available should you need to call for emergency assistance. A copy of the original form is as valid as the original. You should talk to the person you have named as Agent (and Alternates) to make sure that he or she understands your wishes and is willing to take the responsibility of keeping them. You have the right to revoke this advance health-care directive or replace this form at any time.

If you have any questions, please call us at 209-444-5908; Mon-Fri, 8:30AM – 4:30PM.

San Joaquin Coalition for Compassionate Care

Please distribute copies to:

Primary Care Physician ☐

Health Care Agent ☐

Readily Available In Home ☐

Remember, copies are as valid as the original.

ADVANCE CARE DIRECTIVE

Name_____ **DOB** _____/_____/_____ **Date**_____/_____/_____

Part A. – My Health Care Agent.

A.1 I hereby designate the following to be my Primary Health Care Agent and to make health care decisions for me in the event that I am unable to make them for myself:

Name_____ Relationship_____

Address_____

Phone_____ Circle one: Home Mobile Work

If my Primary Agent is not willing, able or available to make health care decisions for me, or if I revoke my Primary Agent's authority, I designate the following act as my First Alternate Agent:

Name_____ Relationship_____

Address_____

Phone_____ Circle one: Home Mobile Work

If my First Alternate Agent is not willing, able or available to make health care decisions for me, or if I revoke my First Alternate Agent's authority, I designate the following act as my Second Alternate Agent:

Name_____ Relationship_____

Address_____

Phone_____ Circle one: Home Mobile Work

A.2 Agent's Authority: My agent is authorized to make all health care decisions for me, including decisions to provide, or withhold or withdraw artificial nutrition and hydration and other forms of health care to keep me alive; choose a particular physician or health care facility; and receive or consent to release medical information and records, except as I state here:

_____

_____

_____

(Additional writing space on Page 9 if needed)

A.3 When Agent's Authority Becomes Effective: My Agent's authority becomes effective when my Treating Physician determines that I am unable to make my own health care decisions unless I initial the following line.

_____**If I initial this line, my Agent's authority to make my health care decisions for me takes effect immediately.**

A.4 Agent's Obligation: My Agent shall make health care decisions for me in accordance with this Advance Health Care Directive, any instructions I give in **Part B** of this form, and my other wishes to the extent known by my Agent. To the extent that 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 by my Agent.

A.5 Agent's Post Death Authority: My Agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in **Part C** of this form:

_____

_____

_____

(Additional writing space on Page 7 if needed)

A.6 Nomination of Conservator: If a conservator of my person needs to be appointed for me by a court, I nominate the Agent designated in this form.

_____**If I initial this line, I nominate the Alternate Agent(s) whom I have named only if my Primary Agent is not willing, able or reasonably as a conservator.**

Part B. – Instructions for Health Care. You may strike out any wording you do not want.

B.1 End-Of-Life Decisions: I direct my health care providers and others involved in my care to provide, withhold or withdraw treatment in accordance with the choice I have marked below:

_____**If I initial this line, I Choose Not To Prolong.** I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible conditions that will result in my death in a relatively short time.

OR

_____**If I initial this line, I Choose To Prolong.** I want my life to be prolonged as long as possible within the limits of accepted medical treatment standards.

B.2 Relief from Pain

_____**If I initial this line, I request relief from pain.** I direct that treatment for alleviation of pain or discomfort be provided at all times.

B.3 Other Wishes: (If you do not agree with any of the choices above and have different or more specific instructions, or if you wish to add to the instructions you have given above, please do so here:

***Please note that if you –DO NOT- want to receive Cardiopulmonary Resuscitation (CPR), you must complete a Physician Orders for Life-Sustaining Treatment form (POLST→pink form) stating your wishes and signed by you and your Treating Physician. Attach your POLST to this Advance Healthcare Directive.**

_____

_____

_____

(Additional writing space on Page 7 if needed)

Part C. - Donation of Organs at Death. Upon my death:

_____**If I initial this line, I do not wish to give any organs, tissues or parts.**

_____**If I initial this line, I give any needed organs, tissues or parts.**

_____**If I initial this line, I give the following organs, tissues or parts only:**_____

_____

My gift is for the following purposes (circle all that apply)

Transplant Therapy Research Education

Part D. – My Treating Physician (Optional).

D.1 I hereby designate the following to be my Treating Physician:

Name_____

Address_____

Phone_____ Circle one: Mobile Office

Part E. – Signature

E.1 Effect of a Copy: A copy of this form has the same effect as the original.

E.2 Signature: _____ **Date**_____/_____/_____

E.3 Statement of Witnesses: I declare under penalty of perjury under the laws of California:

1. 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,
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 Agent by this Advance Directive,
5. That I am not the individual's health care provider, and employee of the individual's health care provider, the operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of a residential care facility for the elderly, and
6. that I am a legal adult.

E.3 Statement of Witnesses (cont'd)

First Witness

Print Name_____

Address_____

Signature of Witness_____ Date_____/_____/_____

Phone_____ Circle one: Mobile Office

Second Witness

Print Name_____

Address_____

Signature of Witness_____ Date_____/_____/_____

Phone_____ Circle one: Mobile Office

E.4 Additional Statement of Witnesses: At least one of the above witnesses must also sign the following declaration:

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.

Signature of Witness_____

Phone_____ Circle one: Mobile Office

Signature of Witness_____

Phone_____ Circle one: Mobile Office

Part F – Special Witness Requirement if in a Skilled Nursing Facility: The Patient Advocate or Ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a Patient Advocate or Ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code:

Print Name_____

Address_____

Signature of Witness_____ Date_____/_____/_____

Phone_____ Circle one: Mobile Office

Certificate of Acknowledgment of Notary Public: (Not required if signed by two witnesses)

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of the document.

State of California, County of _____

On this_____/_____/_____ (date) before me _____,

Notary Public, personally appeared_____ (name of signer) who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the forgoing paragraph is true and correct.
WITNESS by my hand and official seal.

Seal

Signature of Notary_____

Phone_____ Circle one: Mobile Office

Additional Writing Space: Please use this page for the continuation or addition of instructions that you would like to make known.