

# 加州預立醫療指示資訊

填寫本表單以便在病重時表達治療的意願。本表單可讓您：

- **選擇一名健康護理代理人。**當您病得太重而無法自己做醫療決定時，健康護理代理人能幫您做決定。
- **做出您自己的健康護理選擇：**您可以選擇您想要哪類的健康護理；如此一來，當您病得太重而無法自己做決定時，您的照顧者就不必猜測您的想法。

## 如果我不選擇一名健康護理代理人，會如何？

當您病得太重而無法自己做決定時，您的醫生將請您最親近的家屬幫您做決定。如果您想選擇家屬以外的人當代理人，您必須將他/她的姓名寫在這份表單上。

## 我的健康護理代理人可以做什麼樣的決定？

同意、否決、更改、停止或選擇：

- ✓ 醫生、護士、社工
- ✓ 醫院或診所
- ✓ 藥物或檢驗
- ✓ 您去世後，遺體和器官的處理方式

## 您的代理人還可能做其他決定：

- ✓ **維生治療** - 設法幫助您延長生命的醫療護理
- ✓ **CPR 心肺復甦術** - 可能包括：
  - 用力壓您的胸，保持您的血液打進身體各部位
  - 施以電擊，讓您的心臟恢復跳動
  - 將藥物注入您的靜脈
- ✓ **呼吸器** - 這類機器能將空氣打進您的肺部並幫助您呼吸。當您使用呼吸器時，將無法說話。
- ✓ **洗腎透析** - 當您的腎臟停止作用時，用機器幫您清血液。
- ✓ **餵食管** - 當您無法吞嚥時，用管子為您餵食。管子可從喉嚨插進您的胃，亦可用手術放入您的胃。
- ✓ **輸血** - 將血液注入您的靜脈。
- ✓ **手術**
- ✓ **藥物**
- ✓ **臨終護理** - 如果您可能不久人世，您的健康護理代理人可以：
  - 請一位心靈帶領者過來
  - 決定讓您在家裡或醫院過世

您的健康護理提供者將回答您對這份重要文件的任何問題。

~ 如果您想要一份預立醫療指示表單，請向診所工作人員索取 ~

關於預立醫療指示的更多資訊，請瀏覽：

<https://www.hpsm.org/health-information/older-adults>

**PART 1  
POWER OF ATTORNEY FOR HEALTH CARE**

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

\_\_\_\_\_  
(name of individual you choose as agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(ZIP Code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

\_\_\_\_\_  
(name of individual you choose as first alternate agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(ZIP Code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

\_\_\_\_\_  
(name of individual you choose as second alternate agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(ZIP Code)

\_\_\_\_\_  
(home phone)

\_\_\_\_\_  
(work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box , my agent's authority to make health care decisions for me takes effect immediately.

# ADVANCE HEALTH CARE DIRECTIVE FORM

(1.4.) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 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.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make donate my organs, tissues, and parts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

---

---

---

(Add additional sheets if needed.)

(1.6) 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 that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

## PART 2 INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: 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:

(a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

(b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

---

---

(Add additional sheets if needed.)

(2.3) 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:

---

---

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS, TISSUES, AND PARTS AT DEATH
(OPTIONAL)

(3.1) [ ] Upon my death, I give my organs, tissues, and parts (mark box to indicate yes).
By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

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

- (a) Transplant
(b) Therapy
(c) Research
(d) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (ZIP Code)

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (ZIP Code)

(phone)

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

\_\_\_\_\_  
(date) (sign your name)

\_\_\_\_\_  
(address) (print your name)

\_\_\_\_\_  
(city) (state)

(5.3) 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, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness

Second witness

\_\_\_\_\_  
(print name) (print name)

\_\_\_\_\_  
(address) (address)

\_\_\_\_\_  
(city) (state) (city) (state)

\_\_\_\_\_  
(signature of witness) (signature of witness)

\_\_\_\_\_  
(date) (date)

(5.4) 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) (signature of witness)

**PART 6  
SPECIAL WITNESS REQUIREMENT**

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. 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.

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(sign your name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(city) (state)