Информация о предварительном медицинском указании для штата Калифорния

Посредством этого бланка Вы сможете выразить свои пожелания относительно лечения на случай, если Вы тяжело заболеете. Этот документ позволяет Вам:

- **Выбрать представителя по вопросам лечения.** Представитель по вопросам лечения — это человек, которому разрешается принимать медицинские решения вместо Вас в ситуациях, когда Вы находитесь в тяжелом состоянии и не можете принимать решения самостоятельно.
- **Сделать собственный выбор в отношении медицинского обслуживания.** Вы можете указать, какое именно медицинское обслуживание Вам следует предоставлять в случае, когда состояние Вашего здоровья не позволяет Вам принимать решения. Лица, оказывающие Вам медицинскую помощь, будут действовать в соответствии с Вашими указаниями.

Что если я не выберу представителя по вопросам лечения?
Если Вы окажетесь в ситуации, когда состояние Вашего здоровья не позволит Вам принимать решения самостоятельно, врачи обратятся к ближайшим родственникам, чтобы они принимали решения вместо Вас. Если Вы хотите, чтобы такие решения принимал человек, не являющийся Вашим родственником, Вы должны указать его или ее имя в этом документе.

Какого рода решения сможет принимать мой представитель по вопросам лечения?
Он может принять рекомендации, отклонить их, заменить, отменить или выбрать:

- ✓ врачей, сестринский(-ого) персонал(-а), социальных работников
- ✓ больницы или клиники
- ✓ лекарства или анализы
- ✓ действия с Вашим телом или органами после смерти

Ваш представитель также может принимать решения по следующим вопросам:

- ✓ **Лечение, направленное на поддержание жизнедеятельности** — медицинское обслуживание в целях попытаться продлить Вашу жизнь
- ✓ **Сердечно-легочная реанимация** — может включать следующие действия:
  – сильные нажатия на грудную клетку, чтобы поддерживать перекачивание крови по телу
  – воздействие электрическим разрядом, чтобы запустить работу сердца
  – внутривенное введение лекарств
- ✓ **Аппарат искусственного дыхания** — он нагнетает воздух в легкие и дышит вместо вас. Когда пациент подключен к такому аппарату, он не может говорить.
- ✓ **Диализ** — процедура очистки крови на специальном аппарате в ситуациях, когда не работают почки.
- ✓ **Зонд для питания** — трубка, которая используется для кормления, если человек не может глотать. Эту трубка проходит через горло в желудок. Также ее можно ввести в желудок при помощи хирургического вмешательства.
- ✓ **Переливания крови** — процедура, при которой в вену вводят кровь.
- ✓ **Хирургическое лечение**
- ✓ **Лекарства**
- ✓ **Уход до конца жизни** — если есть вероятность близкой смерти, представитель по вопросам лечения может:

– позвонить духовному лицу
– решить, следует ли Вам оставаться в больнице или вернуться домой

Ваш поставщик медицинских услуг ответит на все вопросы, касающиеся этого документа.

~ Если Вам нужен бланк предварительного указания, скажите об этом персоналу клиники ~

Более подробные сведения о предварительном медицинском указании представлены на веб-странице https://www.hpsm.org/health-information/older-adults

ADVANCE HEALTH CARE DIRECTIVE FORM

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.

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(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 wiling, 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.)

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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)

ADVANCE HEALTH CARE DIRECTIVE FORM

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)

ADVANCE HEALTH CARE DIRECTIVE FORM

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)

(Amended by Stats. 2018, Ch. 287, Sec. 1. (AB 3211) Effective January 1, 2019.)