Información de Cuidado Médico por Adelanto de California

Esta forma deja que usted indique como usted quiere ser atendido en el caso que muy enfermo. Le deja:

- **Escojer a un representante para la atención a la salud.** Un representante para la atención a la salud es una persona que puede tomar decisiones médicas en su nombre si usted está demasiado enfermo para hacerlo.
- **Hacer sus propias decisiones sobre su cuidado médico.** Le permite escojer qué tipo de atención médica qué usted desea. De esta manera, los quien lo atiendan no tendraán qué adivinar qué desea usted si está demasiado enfermo para decirles ustes mismo.

¿Qué pasa si no elijo a un representante de atención a la salud?
Si usted está demasiado enfermo para tomar sus propias decisiones, sus médicos le pedirán a sus familiares más cercanos que tomen decisiones en su nombre. Si usted desea que su representante sea alguien fuera de su familia, debe escribir el nombre de la persona en esta forma.

¿Qué tipo de decisiones puede tomar mi representante?

Dar permiso, rechazar, cambiar, parar, o elegir:

- ✓ a sus médicos, enfermeras, y trabajadores sociales
- ✓ sus hospitales o clínicas
- ✓ medicinas o exámenes medicos
- ✓ decidir que va a pasar con su cuerpo y órganos después que usted muera

Otras decisiones que puede tomar mi representante

- ✓ **Tratamientos para mantener la vida** -atención médica para tratar de ayudarle a vivir mas tiempo
- ✓ **RCP o resucitación cardio-pulmonar** - Esto puede incluir:

– presionar fuertemente sobre su pecho para mover su sangre
– toques elétricos para “pasar corriente” a su corazón
– darle medicinas por las venas

- ✓ **Máquina para respirar o ventilador mecánico** - La máquina bombea aire a sus pulmones y respira por usted. Usted no puede hablar cuando esta conectado a la máquina
- ✓ **Diálisis** - Un aparato que limpia su sangre si sus riñones dejan de funcionar
- ✓ **Sonda de alimentación** Un tubo que se usa para alimentarlo si usted no puede tragar. Se pone por la garganta hasta el estómago. También se pone con una operación
- ✓ **Transfusioines de sangre** - Dar sangre por sus venas
- ✓ **Cirugía**
- ✓ **Medicamentos**
- ✓ **Cuidados al fin de la vida –** si usted se esta muriendo su representante podrá:

– llamar a un lider espiritual.
– decidir si usted se muere en casa o en el hospital.

El médico responderá cualquier pregunta que pueda tener sobre este documento importante.

Si desea una forma de Cuidado Médico por Adelanto, pidasela a un miembro del personal de la clínica.

Para más información acerca de la directiva anticipada de atención de salud, visite 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)

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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.)